Mum's the Word:

A phenomenological exploration of early motherhood

Thesis submitted for

Doctor of Philosophy Degree

by

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Declaration

This is to certify that:

a. this thesis comprises my original work toward the Doctor of Philosophy degree and due acknowledgement has been made in the text of all other materials used;
b. the work has not been submitted previously, in whole or part, to qualify for any other academic award;
c. the content of the thesis is the result of work which has been undertaken since the official commencement date of the research program;
d. ethics procedures and guidelines have been followed; and
e. any editorial work, paid or unpaid, carried out by a third party is acknowledged.

Leanne Sheeran
(February 2012)

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Thesis: 'Mum's the Word': Exploring Early Motherhood

List of Presentations at Refereed Conferences and Seminars

(State, National and International)

2010

- 'Early Motherhood and Women's Experiences of their Relationship', Poster presentation at *Queen Elizabeth Centre's 6th Biennial International Conference* held at the Sebel Hotel, Albert Park, Melbourne, 11-12th Nov 2010.

2008

- 'Recruiting and Retaining Participants: A Case Study of an Early Motherhood Research Project' paper presented at the 4th *Collaborative Victorian and Tasmanian Deans of Nursing and Midwifery Conference,* held at RMIT University, Bundoora, Victoria, 4 Sept 2008.

- 'Women's Experiences of Learning to Feed', paper presented at *Reaching Out to Vulnerable Families: Achieving Better Outcomes for Children, Queen Elizabeth Centre 5th Biennial International Conference* held at the Sebel Hotel, Albert Park, Melbourne, 20 Nov 2008.

2007

- 'Women's Experiences of Early Motherhood: Implications of Nursing Practice'. *Paper presented at Partnerships in Practice*. *Australian Association of Maternal, Child and Family Health Nurses 2nd National Conference*, held 5 May 2007 at Sydney Convention and Exhibition Centre.

- 'Phenomenology, van Manen and Nursing Practice'. Paper presented to the *Victorian and Tasmanian Deans of Nursing and Midwifery 3rd Annual Collaborative Research School for Higher Degree Students in Nursing,* held at Deakin University, (Burwood Campus), 27-28th September, 2007).

2006

- 'Living the Transition from Woman to Mother'. Paper presented at the *Victorian Deans of Nursing and Midwifery 2nd Collaborative Research School* held at Melbourne University, 18-19 September 2006.

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2007

- 'Mum's the Word': Exploring early motherhood'. Paper presented an outline of my research project and some initial findings to the '*Social Determinants of Women's Health in Thailand and Australia' Workshop held by Division of Nursing and Midwifery*, RMIT University, at Bundoora Campus, 27th November 2007.

2006

- 'Early Motherhood: Women's Experiences of Breastfeeding'. Paper presented at the *Mitchell Shire Council seminar 'The Early Days'* held at Broadford 19th May 2006.

2005

- 'Introduction to 'Mum's the Word: Exploring early motherhood' Research Project. *Paper presented to Mitchell Shire Council Maternal and Child Health Nurses' Team Meeting* October 2005.

Abstract

Having a baby and becoming a mother signifies a major transition in a woman's life. This thesis investigates and gives voice to women's experiences of early motherhood. van Manen's phenomenological approach was used as the theoretical framework for this research. The study aimed to explicate the lived experience of early motherhood for a cohort of 13 women having an essentially normal pregnancy.

The study was located in a rural municipality in Victoria, Australia. A purposive sample of adult women was selected as they were experiencing a healthy pregnancy with their first child and willing to discuss their experience of early motherhood. Data were collected from participants using individual sequential audiotaped in-depth interviews and from personal journals kept by four of the participants. Interviews were held at three key stages of early motherhood: late pregnancy, and approximately two weeks and eight weeks after giving birth. Most interviews were about an hour in duration and all occurred in participants' own homes or the homes of extended family. Interview data were transcribed verbatim and analysed using van Manen's phenomenological approach.

The insights of the study are presented chronologically around the pregnancy, labour and birth and postnatal periods. For these first time mothers pregnancy resulted in a raft of changes to their lives, Women shared rich descriptions of their physical and emotional experience of pregnancy and the themes revealed about women's experience of their relationships at this time focussed on their relationships with their partners, their unborn baby and their mother. 'Waiting' and 'wondering' were also dominant themes in women's experience of pregnancy. Key themes that emerged from women's descriptions of their labour and birth were the experience of labour, managing labour pain, support to get through labour and birth, and the concerted effort of second stage. Other themes uncovered included women's surprise at the amount of blood at delivery and birthing in a technological age. In the postnatal period, the insights concerning women's experience of early motherhood were grouped around the themes of living the physical experience of early motherhood, learning to feed, learning to mother and relationship changes.

This research study contributes new insights into the phenomenon of early motherhood that have implications for midwifery and MCH nursing practice. Implications from the study are presented in the form of a model that integrates clinical practice, education and research. The overarching implication is that midwives and MCH nurses develop a framework for care that fosters a supportive, nurturing, 'holding' environment for women across pregnancy, the perinatal and early motherhood periods. Steps to operationalise these implications are detailed.

Prologue

Early motherhood is a topic in which I hold both a personal and professional interest. It is important to me to declare my interests and to elucidate the perspective from which I am writing. On a professional note I am qualified as a registered nurse, a midwife and a maternal and child health nurse. I am also the mother of three children. I have worked as a sole practitioner in maternal and child health nursing in rural areas of Victoria, Australia, for the past 20 years. In recent months I have taken on a university teaching role in maternal and child health. As a lecturer I am responsible for teaching postgraduate students (qualified in both nursing and midwifery) the art and science of maternal and child health nursing.

The Victorian Maternal and Child Health service is funded in partnership between local and State governments, and operates as a voluntary service, free to families at the point of entry. This service is offered universally to all families and is therefore non-stigmatised. While it is a child focused service, it also has a family centred approach and is offered in a collaborative, partnership style (Department of Human Services (DHS) 2004). My clinical role in maternal and child health involved providing primary health care services for families with young children aged birth to six years. It involved assessing, promoting, monitoring and advising regarding child health and development, and appropriate referral to other services as required. In addition, my role involved supporting parents and families with health and parenting issues and linking them into local community and support networks. As a maternal and child health (MCH) nurse in a rural municipality, my role included home visiting, individual centre based consultations in small rural clinics and facilitating group programs for parents. A MCH nurse working full time (38 hours per week) has an average annual caseload of approximately 780 enrolled children aged 0-6 years. This would equate to approximately 390 families, of which 130 per year have a newborn baby. Smaller communities have a similar caseload on a pro-rata basis.

The following vignettes illustrate my early professional encounters with motherhood, and indicate my personal responses. These life experiences significantly contribute to my

interest in the topic of early motherhood. They are presented to reveal something of my own experience as a nurse and midwife and to highlight the journey I have taken to come to this research study.

I worked as a general nurse and a midwife before I became a mother myself. As a witness I observed the experience of labour and childbirth to be powerful. It inspires wonder and awe, and involves strength and courage and perseverance. I was a 19 year old student nurse when I witnessed birth for the first time, and it had a profound impact on me.

> The pregnant woman laboured hard. She was quite distressed by the pains of her labour. As the hours dragged by she became increasingly anguished. The pethidine injection and the nitrous oxide and oxygen gas took the edge off her pain, but didn't have much real impact as she lay on a delivery suite bed and struggled to address and manage each pain.
>
> The second stage of labour was quite quick. This was her second child. The woman exerted and strained her whole body and being as she pushed through the contractions to give birth to her child. I was tearful as the baby girl was born and lifted to her mother's chest.
>
> One of the most amazing aspects about this event was the dramatic and rapid shift in the woman's demeanor once her baby was born. One moment she was in abject misery, groaning and grunting and straining to push her baby into the world; and the next moment she was overwhelmed with joy and pleasure and totally focused on her newborn daughter. The change in her demeanor and behaviour was like changing a channel on the television – a totally different situation and story.

Then as a new graduate nurse I spent three months working in a remote mission hospital on the island of Ambae, Vanuatu. The births I observed and assisted did not involve much technology. The nearest doctor was on another island, a light aircraft flight away.

> A truck pulled up in the village one day, just outside the small island hospital. In the tray area at the back of the truck a new mother lay, holding a bundle of wraps that kept her newborn baby warm. The woman was from a village some miles away and had been transported to the hospital, as her placenta had not been delivered. She was very pale and weak after an excessive blood loss. A coconut shell was attached to the umbilical cord and lay between her legs to prevent the cord being retracted with the retained placenta.

On another evening a young girl ran to the hospital to alert us that her mother was in labour a short distance up a track, and was unable to walk any further. A colleague and I set off with a basic bag of equipment. We traveled some way up the narrow path through the jungle before we came to the woman. It was dark, but we found this woman squatting on the ground and holding her newborn baby under the armpits. She had given birth alone on a jungle path but she and her baby were well.

Becoming a mother is both scary and wonderful. Physically, childbirth usually involves a lot of pain. It can also be unpredictable and if complications occur it can sometimes be hazardous. My interest in childbirth and motherhood is underpinned by these early midwifery encounters. They have seeded the questions in my mind about what it means to be mother, to carry a baby, to give birth and to nurture a child. These experiences germinated a keen interest in midwifery which means 'with woman' (Fraser and Cooper 2009), and maternal and child health nursing.

After studying and then working as a midwife for several years I became a mother myself. These vignettes explicate aspects of my personal experience of early motherhood. With my personal experience of motherhood I gained new understandings about women and motherhood.

My first child was born after a long labour. My labour pain was eventually managed with the full spectrum of tertiary hospital facilities, culminating in an epidural anaesthesia. As my baby exhibited signs of foetal distress during the second stage of labour a registrar walking past was called in to perform an emergency forceps delivery. My own obstetrician was attending women at another hospital across the suburbs of Melbourne.

I recall the intensity of my labour pains and how they seemed to consume all my being. The instinct to hold and protect my baby from the moment he was born is etched in my brain. I remember experiencing a total paradigm shift in terms of being lost in the tempest of the labour to be transported to heaven when I saw and held my child immediately he was born. Through this physical and biological experience of childbirth I had become a mother.

Previous research on becoming a mother has noted that 'Whilst the act of giving birth determines motherhood in the biological sense, our research shows that in the emotional

and personal sense 'becoming a mother' takes some time' (Barclay, Everitt, Rogan Schmied & Wyllie 1997:725). After the excitement and adrenaline of the birth subsided, I found motherhood to be a very challenging experience.

> I was physically exhausted after my first child was born. My labour had lasted 17 hours and my body felt a wreck. The epidural and foetal monitoring paraphernalia were removed soon after the birth. The intravenous line and urinary catheter remained connected to my body for another 24 hours. I felt traumatised by the physical changes in my body and by soft tissue injuries associated with the emergency assisted delivery. I was also mentally exhausted from lack of sleep and the highly charged emotional experience. My baby was born. My baby had left the inside of my body and was now beside my bed in a clear perspex cot. He had experienced a hurried evacuation from my body. His face was scrunched and swollen from the rapid extraction, and he cried.
>
> The early weeks of motherhood were more demanding than I anticipated, even though I had several years work experience as a midwife before I became a mother. My physical recovery took several weeks. My apprenticeship into motherhood was overwhelming. There were constantly new things to learn about my baby, even though I had cared for newborns professionally. Establishing feeding, learning how to settle a distressed baby, balancing relationships with family and friends and coping with unrelenting fatigue were skills I struggled to manage. Surprisingly I also had to discover or confront many things about myself. Having a child, becoming a mother, was an intense experience with rich joys and unexpected challenges that I had not previously imagined. Despite my professional experience as a midwife, becoming a mother seemed to take some time.

My experience of working in maternal and child health nursing has led me to recognise that the experiences of families with young children have some common threads but are individually unique. Becoming a mother is a role or job women seem to grow into over time. Individuals have their own way and pace of defining and establishing their role for themselves and their family. It takes women a while to be comfortable in the new person they have become through the physical act of giving birth. As I worked with families and observed women and their infants it is puzzling to wonder about the journey they travel. What is it like to be a mother? What is the lived experience of early motherhood? This was the beginning of my journey into exploring women's experiences of early motherhood.

Chapter 1

Introducing the study

'Whilst the act of giving birth determines motherhood in the biological sense, ... in the emotional and personal sense 'becoming a mother' takes some time'

(Barclay, Everitt, Rogan Schmied & Wyllie 1997:725)

Introduction

Becoming a mother is a significant event in women's lives. This research program explored women's experiences of early motherhood and aimed to explicate this phenomenon. As the research was located in the realm of lived experience, a phenomenological approach to inquiry was employed.

The introductory prologue has identified the researcher's professional and personal interest in the topic of early motherhood. This chapter introduces the purpose of the research program and defines the key term 'early motherhood'. Contemporary representations of motherhood, the Australian context, background literature, and the rationale of the study are expounded. This chapter concludes by outlining the relevance of the study and offering an overview of the thesis.

Definitions

While the focus of this study was early motherhood, it does not imply that the role of fathers in families is of less significance. The intention of this thesis is not to minimise or ignore the significant role of fathers in families. It is also important to note that it is recognized that contemporary families are configured in various ways. Single parent families, blended families, same sex relationships as well as the traditional nuclear family are all recognized as representing the range of families that exist and support the growth,

development and nurturing of children. As the concept of families is so broad and the roles of members within families so varied, this study focused on the lived experience of mothers. The period of early motherhood that was the focus of this research is the period from late pregnancy, around 34-40 weeks gestation, until 6-8 weeks after the birth. This research explicated women's experiences of early motherhood by focusing on three periods within the time defined above, which the author considered to be windows of opportunity to explore this phenomenon. These periods were antenatally at approximately 34-40 weeks, and then at 2-3 weeks and 6-8 weeks postnatally. The core question asked of participants was: 'What is your experience of being a mother at this time?'

For most women, 'pregnancy and childbirth are normal life events requiring minimal intervention' (NCT/RCM/RCOG 2007:4). For the purpose of this study 'normal' pregnancy has been defined as an uncomplicated or low risk pregnancy experienced by a fit and healthy woman. This definition has been formulated after consideration of definitions used by McCarthy, Capullari, Zhu and Spellacy (2006) and the Royal College of Midwives (2005). Women experiencing a healthy and 'normal' pregnancy are usually expected to give birth to healthy newborns (NCT, RCM & RCOG 2007).

Picturing Motherhood: The realities of motherhood

The meaning of motherhood has been explored by community development activities in some Australian communities. (Wheeler 2003; Women's Health Goulburn North East (WHNE) 2003). For instance, a community development and visual arts project in rural Victoria, *Picturing Motherhood,* involved women exploring new ways to express their own experiences of early motherhood. In this project, women photographed aspects of their lives that they felt were underrepresented in conventional representations of early motherhood. These missing pictures of motherhood were explored and collated to give a richer understanding of women's lives during early motherhood (Wheeler 2003). The result was an exhibition that inspired discussion and comprised images that do not appear in magazines or books or even photograph albums. This exhibition reflected the wide variety

of emotions that define motherhood and provided a window into the 'joys, fears, tears, frustrations, trials and pleasures that comprise the world of mothering' (Wheeler 2003:26).

A physically powerful photograph that touched this writer profoundly was the image of a young mother curled up in the foetal position on the floor. Eight pairs of hands and arms, all shapes and sizes simultaneously reached for this woman. This challenging picture was titled *'Everyone wants a piece of me ('Gimme some space')* (Wheeler 2003). It beautifully depicts the overwhelming sense of overload and 'give-give-give' described by new mothers. The tightly curled up and withdrawing woman seemed to be silently screaming for a small piece of space for herself (Wheeler 2003). Another photograph also filled the gap in contemporary representations of motherhood. This photograph displayed an image of a disheveled sleepy mother in flannelette pyjamas and messy hair breastfeeding a baby in the early hours of the morning- not what you see in glossy magazines. The mother in the photograph commented that:

> *Normally I would never, ever have contemplated letting people see a photo like that, but I just said, yeah, that's fine. And then at the exhibition, I'd expected that my husband and kids would ask why I put that photo in, but they just seemed to accept it. They thought it was a good photo* (Wheeler 2003:25).

Another Picturing Motherhood project was undertaken in Indigo shire, northern Victoria (WHNE 2005). As before, rural women photographed aspects of their lives that expressed and documented real motherhood experiences. The images were brought together in an exhibition titled *'Beyond the Myth: The Realities of Motherhood'* held in the Bright Art Gallery June- July 2005. The exhibition celebrated the diversity of early motherhood experiences through photographs, stories, poetry and prose. This exploration of motherhood provided a deep and honest reflection of motherhood and offered insight into the lived experience of early motherhood.

As an observer, it was confronting to consider the stories behind the photographs and to reflect on women's communications through their words and poetry. It was sometimes hard

to sit with and experience the emotions underpinning the words, not because they were not clear, but because they were so raw. The exhibition documented the love, joy, sense of achievement and pride that is commonly linked with motherhood. It also removed the veil to uncover some of the negative experiences of motherhood: pain, loss of identity, boredom, monotonous household duties, nappies, and vomit. A number of photographs in this exhibit addressed the issue of early motherhood and laundry. One whimsical photograph showed a mother pegging out hundreds of disposable nappies on a rotary clothesline, while a baby sat in a washing basket at her feet. This image was particularly challenging for this writer to grasp the communication of this artist. Was it a statement about the workload of motherhood; the hundreds and thousands of nappies to change? Or was it a comment on the loneliness of motherhood; the volume of care the baby required by the women home alone? Perhaps it was a comment about the craziness of motherhood, a mother losing the plot and pegging disposable nappies on the clothes line? Another photograph presented an interesting image of two mothers swinging with the washing from a rotary clothesline. The photographs challenged public perceptions of motherhood, and raised questions about the meaning of motherhood.

Sculpture: Another medium for Visualising Motherhood

Other artistic forms have been used to create images and challenge understandings of motherhood. The *Pregnant Woman* is a fibre glass, resin and silicone sculpture created by Mueck in 2002 and displayed at the Art Gallery of Victoria February 2005. She stands 2.5 metres high and appears to be at full term in her pregnancy. Her hands are clasped behind her head, and she seems to be focusing on her breathing or a contraction of early labour. Her skin appears to be goose bumped and has visible veins and minor skin blemishes. Intricate details of the pregnant body are revealed in her stance: she exhibits the lumbar lordosis associated with pregnancy and an altered centre of gravity, her breasts are full and reveal the normal pregnancy changes such as darkened areola and Montgomery's follicles; her abdomen is swollen with her unborn baby and displays the vertical linea negra line and an everted umbilicus. The pregnant woman has her eyes closed, which portrays a weariness or sense of concentration. There are beads of moisture on her face and even a tear above her

cheek. Her face is tender and vulnerable. She looks worn out, weighed down. Carrying the baby within her body makes her look exhausted. She is utterly convincing. This sculpture challenges observers to imagine her feelings and the lived experience of motherhood.

Other pieces Mueck has created are also realistic and either larger or smaller than life size as he likes to manipulate scale. His sculpture titled *Mother and Child* (2001) portrays a naked mother laying flat on her back with her newborn baby perched on her abdomen. This sculpture depicts the moments immediately after child birth. The mother's face and hair are damp with perspiration and she appears fatigued and dazed. Her baby rests in a semi foetal position, glistening with the dampness of the amniotic fluid. The mother and child are still connected by the umbilical cord and the not yet delivered placenta. These sculptures of Mueck's are illustrated in Figures 1 and 2 and are included with permission. Works such as these add to our understanding of motherhood.

Another form of contemporary motherhood sculpture are the carvings by Susan Lordi. These pieces in the Willow Tree series are small enough and sufficiently affordable to be owned by families. Figure 3 *Angel of Mine* stands 22 centimetres tall and 6 centimetres across. This simple female form has no facial features, a characteristic of the series. However the artist reveals expression through gestures such as the tilt of the woman's head, the way she holds the loosely swaddled small baby to her chest and snuggles it into her neck. This image seems to portray the gentle nurturing aspects of early motherhood. There is a profound sense of motherhood providing physical and emotional containment and safety for the baby.

Note: Figures 1, 2 and 3 have been removed from the thesis after examination for copyright reasons. Pages 12 – 13 have been left deliberately blank.

Figure 4 *Our Gift* is another sculpture in the Willow Tree series. It stands 22 centimetres tall, and is 9 centimetres across. This sculpture comprises a couple holding a young baby. As in *Angel of Mine* the positioning of the parents' bodies, the incline of their heads and the placing of their hands all communicate the experience of early motherhood. The parents in this sculpture have a shared focus in nurturing the baby. Another striking feature is the way the woman is being held by the father and how both parents are 'holding' the baby-both physically and emotionally.

Note: Figure 4 has been removed from the thesis after examination due to copyright reasons.

Australian Context

In 2005, (when most interviews were conducted), there were 272,419 births in Australia (Laws, Abeywardana, Walker & Sullivan 2007). Of these, 66,654 births occurred in Victoria (Laws et al. 2007). In 2005, the mean age of women giving birth in Australia was 29.8 years (Laws et al. 2007). The average age of first time mothers giving birth in Australia was 28 years, increased from 26.6 years in 1996 (Laws et al. 2007).

It is acknowledged that in the context of worldwide maternity services, Australia is a fortunate country. There are several reasons for this. Firstly, almost every pregnant woman in Australia attends antenatal care. Midwives are involved in antenatal care and education and provide care to women during labour and the immediate postnatal period. Secondly, most births in Australia occur in hospitals or hospital based birth centres (99.4 cent in 2005), with a home birth rate of 0.2 per cent in 2005 (Laws et al. 2007). The median length of postnatal hospital stay in 2005 was 3.0 days for women in a public hospital and 4.0 days for mothers in a private hospital. Women who had instrumental vaginal deliveries had a median length of stay of 4.0 days, while women who experienced a caesarean birth had a median length of postnatal stay of 5.0 days (Laws et al. 2007). In Victoria women birthing in public hospitals were offered postnatal domiciliary care by a midwife, which was accepted by over 90 per cent of new mothers in 2005-06 (Veitch, Davey & King 2007).

Another reason that Australia is a fortunate country is because of the low maternal mortality rate. For the triennium 2003-2005 the maternal mortality rate in Australia was 8.4 per 100,000 women giving birth (Sullivan, Hall & King 2008). This compares favourably with the maternal mortality rates in other developed countries (United Nations Children's Fund (UNICEF) 2008). This contrasts starkly, however, with the situation in developing countries, where there is limited access to skilled care during birth and emergency care when required. For instance, the average maternal mortality rate for developing countries and territories is 450 maternal deaths per 100,000 births, while in West and Central Africa the regional maternal mortality rate is l,100 maternal deaths per 100,000 births (UNICEF 2008). Significantly, more than 99 per cent of maternal deaths worldwide occur in

developing countries (UNICEF 2008). Such mortality rates demonstrate a striking example of inequality in living conditions, population health, nutrition and maternity care. The Australian perinatal death rates are also important to note. At the time of this study (2005) the perinatal death rate was 10.1 per 1,000 births for non-indigenous Australians, while the rate for babies born to Aboriginal and Torres Strait Islander mothers was 19.0 per 1,000 births; highlighting an incredible disparity within our own country (Laws et al 2007). In the main it is possible to explore women's experiences of early motherhood in a privileged country, like Australia, as other aspects of women's experiences of early motherhood such as pregnancy, labour and the postnatal period occur within the safety net of having skilled attendants and access to emergency care if required.

In Australia, several options for maternity care are available to pregnant women. Contemporary medical involvement in birth may involve confirmation of pregnancy, referral to hospital based antenatal care, provision of shared care between the medical clinic and a hospital, or referral to a private specialist obstetrician. Health professionals attending child birth may include midwives, general practitioners (GPs), hospital residents on obstetric rotation, obstetric registrars or specialist obstetricians. While most midwives are employed within the public hospital system, some midwives provide private midwifery care, and a small number are based in the community. Midwives are considered the specialists in normal labour and birth.

There is an array of midwifery models of care in contemporary Australia. A number of the models of care focus on continuity of care which involves women being cared for by a known or consistent midwife during the continuum of pregnancy, labour, birth and the postnatal period (Department of Human Services (DHS) 2004). The 'shared care model' refers to care that is shared between two health professionals, such as a midwife and a doctor, usually a GP. The 'case load midwifery model' describes the situation where one midwife assumes a primary role. 'Team midwifery' is a model where a small group of midwives provide midwifery care to the woman (DHS 2004). In Victoria, the transition between hospital services and home for women accessing public maternity services is facilitated by a domiciliary visit by a midwife. This usually involves a single home visit for

women and infants with no significant wellbeing issues (Department of Education and Early Childhood Development (DEECD) 2010).

Community care for new mothers and their babies becomes the responsibility of maternal and child health (MCH) nurses at approximately 5 days after birth, or after discharge from hospital. Maternal and child health nurses care for families with children aged birth to six years. Most work as sole practitioners in stand-alone community centres, although some are now co-located with child or family services in community settings. In Victoria, Australia, maternal and child health nurses are required to be qualified in general nursing, with postgraduate qualifications in both midwifery and maternal and child health nursing (totaling five years of tertiary education).

Background to the Study

Mothers and motherhood have been explored in other work in the academic literature for many decades. For example, motherhood has been examined as both an institution (Rich 1977) and an experience (Rich 1977; Rubin 1984; Mercer 1986). The medicalisation of maternity care (Oakley 1980), the transition to motherhood (Miller 2005; Nelson 2003; Pridham & Chang 1992; Oakley 1979; 1986), and social support and motherhood (Pridham, Egan, Chang & Hansen 1986; Oakley 1992) have also been studied. Stern, Bruschweiler-Stern & Freeland (1998) explored the inner world of the new mother. A number of studies have also explored the lived worlds of mothers with children in complex situations (Wong 1997; Glasscock 2000; Man 2001). Major issues identified in research about women's experiences of motherhood include: isolation, lack of social support, exhaustion, depression, sense of loss and lack of preparation (Oakley 1979; 1980; 1986; Brown, Lumley, Small & Astbury 1994; Barclay & Lloyd 1996; Barclay et al. 1997; Rogan, Schmied, Barclay, Everitt & Wyllie 1997; Nelson 2003; Miller 2005). The author's previous research about women's experiences of being mothers supports these findings (Sheeran 1997).

Women's own views regarding birthing and postnatal services have been investigated in Ministerial reviews in Victoria, New South Wales and Western Australia (Lumley, Small & Yelland 1990; NSW Department of Health 1989; Health Department of Western Australia 1990). In addition, a large landmark piece of research exploring women's experiences of being mothers was undertaken by Brown et al. (1994). This study surveyed almost 800 mothers eight months after childbirth, and followed up a smaller subgroup with in-depth interviews two years after childbirth (Brown et al. 1994). A key contention of this research was that women's voices were 'missing' from the discourse about motherhood. The literature has also noted the reluctance of women to speak about the emotional impact of motherhood (Elliott 1990; Brown et al. 1994). Women find it hard to voice issues and concerns about the difficult aspects of motherhood (Brown et al. 1994; Sheeran 1997). Maushart (1997) supports this, arguing that women hide their experiences of motherhood behind 'masks'. This work by Maushart (1997) examines the hidden facets and silences about women's experiences of motherhood, and attempts to unravel its unspoken secrets

Rationale and Aim of Study

While the work undertaken on motherhood is extensive, there were significant gaps in the available research. These gaps include a paucity of information about women's lived experiences of early motherhood for women experiencing a normal pregnancy and postnatal period. There is also a lack of literature about women's experiences of early motherhood from both a nursing perspective and phenomenological perspective. As a maternal and child health nurse, this researcher explored the lived experience of early motherhood to address these gaps and generate new knowledge in this area. The aim of this research was:

> *To explicate the lived experience of early motherhood as described by first time mothers.*

Research Question

The research question underpinning the research was:

> *What is the lived experience of early motherhood as described by first time mothers?*

Relevance of the Study

There has been renewed interest by governments in various countries in the importance of the early years of life (Mares, Newman & Warren 2011; Mustard, McCain & Bertrand 2000; Sullivan & Calvert 2004, Edgar 2004). Governments and health workers have been reviewing new literature about infant brain development and the critical importance of the emotional environment in the first three years on later child development, learning and behaviour (Mustard et al. 2000; Gable & Hunting 2000; Oberklaid 2002; Sullivan & Calvert 2004; Mares et al. 2011). Maternal and Child Health nurses provide care to 98 per cent of families with newborn infants, and provide support to families with children 0-6 years of age (DEECD 2011). The period after the birth of a baby is critically important in the journey of early motherhood (Barnes & Rowe 2008; Mares et al. 2011). The rapport developed between the MCH nurse and parents, usually the mother, is pivotal in the work the MCH nurse does in providing primary health care services to children and families and in supporting the family during varying developmental stages and parenting issues (DEECD 2011).

While there are numerous studies examining the lived world experience of motherhood in complex situations such as where infants are in neonatal intensive care units (Wong 1997; Man 2001), or where children have disabilities (Glasscock 2000), the author has been unable to access any contemporary research undertaken about the lived experience of motherhood for women experiencing a normal pregnancy and during the postnatal period. The contemporary literature examining motherhood looks at motherhood very broadly. An example is the landmark research undertaken by Brown et al. (1994), mentioned earlier,

which surveyed women eight months after birth, and followed this up with interviews two years after birth.

Overall, the research literature revealed that women are often overwhelmed and feel inadequately prepared for the intensity of the early motherhood experience (Brown et al. 1994; Barclay et al. 1997; Sheeran 1997), and this is often hidden and not spoken about (Maushart 1997; Stern et al. 1998). As it is often hard for women to voice concerns about the difficult aspects of motherhood, (Brown et al. 1994; Stern et al.) dissemination of this information could assist women in the transition to being mothers.

In contrast to the literature noted above, the current study explored women's experiences of early motherhood during late pregnancy, and the first 6-8 weeks after giving birth via in-depth interviews and journaling. This has provided a focused study of the early motherhood period and addressed the gaps in knowledge in this key transition period. It has produced new knowledge about the lived experience of motherhood during this period.

The insights document and validate both the spoken and usually unspoken facets of women's experiences of early motherhood. The insights also allow women to better anticipate the challenges of early motherhood as well as normalising and informing their experience of it. As a consequence, this research will further contribute to both the community's understanding of early motherhood and also the knowledge base of health and community workers providing care and support to women during the early motherhood period. In summary, it is anticipated that the insights of this research will have the following benefits:

Benefits to the Community:

1. Explicate, document, and validate women's lived experience of early motherhood.
2. Enable women to better anticipate the challenges of early motherhood.
3. Enable women (as mothers) to normalise and inform their experience of early motherhood.

4. Provide new knowledge for policy makers.
5. Increase community understanding about women's experiences of early motherhood.

Benefits to the Professions working with Families with Young Children:

6. Provide greater insight for midwives and MCH nurses into the challenges of early motherhood and further improve their sensitivity to and understanding of women's experiences of being mothers in this critical period and consequently the quality of support they can provide to women and their families.
7. To develop new knowledge relevant to all professionals working with families in the early years such as MCH nurses, midwives, general practitioners, childcare workers and preschool teachers.
8. To enhance existing levels of care and education for parents about parenthood and motherhood.

Thesis Overview

This thesis is arranged in ten chapters. A prologue introduces and identifies the researcher's particular background and interest in the topic of early motherhood. Chapter 1 is the introductory chapter; it defines terms, describes the study context, discusses the background to the topic of early motherhood and the rationale of the study. Chapter 2 reviews the major literature on motherhood, highlighting key themes and unresolved issues. Chapter 3 presents an overview of van Manen's hermeneutic phenomenology (van Manen 1997), the theoretical framework underpinning this research. Chapter 4 outlines the research design and the steps implemented in undertaking the research.

Chapter 5 presents the first of the research insights, which concern women's experiences of early motherhood during pregnancy, Chapter 6 reports on the insights concerning women's experiences of labour and birth and Chapter 7 details the insights concerning women's

experiences of early motherhood in the early weeks after the birth. Then Chapter 8 discusses the insights of the research and explores them in relation to the literature. The insights are discussed in terms of whether they confirm or extend existing knowledge, or add new knowledge.

The final chapters draw the thesis to a close. Chapter 9 presents reflections of the researcher on the research journey, providing a balance to the prologue at the beginning of the thesis, and sharing discernments for other researchers in this field. Chapter 10 concludes the thesis by discussing the strengths and limitations of the study and reviewing the key insights. It synthesises the ideas presented in the thesis and discusses the implications of these for midwifery and maternal and child health practice, education, and research.

Conclusion

This chapter has introduced the research program and its purpose and defined the key terms ‘early motherhood’ and ‘normal pregnancy’ used in this study. Next, contemporary representations of motherhood and the Australian context of motherhood were explored. The background and relevance of the study for midwifery and maternal and child health nursing were also introduced. Finally an overview of the thesis chapters was presented. The next chapter provides a review of the major literature regarding early motherhood.

Chapter 2

Exploring the Literature

Introduction

This chapter introduces and critiques the key literature concerning the phenomenon of early motherhood. The exploration of the literature will begin by consideration of conventional representations of it is depicted in literature. Following on from this will be an exploration of the physical health of new mothers; psychological and emotional wellbeing; and the link between maternal wellbeing and infant health and wellbeing. There will then be an appraisal of the literature related to the transition to motherhood, with a particular focus on women's experiences of early motherhood. Finally, four theories of motherhood are considered.

In keeping with the phenomenological tradition this literature review aims to provide a cursory view of the existing literature for the purpose of establishing the need for this study (Streubert & Carpenter 2011; Taylor & Roberts 2006). The reasoning behind this is that the phenomenological approach endeavours to avoid predetermined suppositions or notions influencing the research project (van Manen 1997). After the research insights have been identified, the major literature review will be conducted which will then inform the discussion of the thesis.

Representations of Motherhood

Conventional Representations: Expectations versus Reality

Conventional representations and expectations of motherhood in Western culture include a number of characteristics: slim good-looking women and happy babies; women, who conceive easily, have uncomplicated pregnancies and natural or low intervention childbirth

with minimal analgesia; confident and attractive women who recover well after the birth and regain their pre-baby shape. The babies of these women grow and develop according to text book guidelines; feed and sleep well; rarely, if ever, cry; and smile beautifully like the babies in magazine advertisements or television commercials. Whilst this description may be a little 'glowing' or enhanced, it is not too different from expectations held by many women prior to beginning the journey of early motherhood.

In Western culture, people are confronted with conflicting views of motherhood. On one side there is the superficial enhanced glorification of motherhood, and on the other side there is the sharply contrasting reality that many women experience. The conventional representations of motherhood are challenged by researchers such as Maushart who unveil the realities of contemporary motherhood and argue that the transformation from woman to mother is a journey of epic proportions (Maushart 1997). In addition Maushart comments on the conspiracy of silence and secrecy that surrounds the realities of motherhood and terms it the 'mask of motherhood' (Maushart 1997:21). This mask becomes the public face of motherhood, drawing a veil over the complexity and chaos of women's lived experience as mothers and minimising the enormity of their work (Maushart 1997). The silence around the unspoken aspects of women's experiences as mothers is captured in the observation that: 'women without children seem disturbingly unprepared for the challenges of motherhood, and that women with children seem disturbingly unprepared to discuss those challenges' (Maushart 1997:17).

While some feminist writers have challenged the discrepancy and paradox between the images of motherhood that women aim to conform to and the reality of women's lives as mothers (Fridan 1963; Chesler 1979), others have examined women's experiences of motherhood as both a source of power and site of oppression (Porter, Short & O'Reilly 2005). Although in some respects there is a wealth of knowledge about motherhood, in other respects the knowledge is very incomplete. There are some aspects of motherhood that remain mysterious. Rich attests: 'We know more about the air we breathe, the seas we travel, than about the nature and meaning of motherhood' (Rich 1976:11). While there is a mystery associated with motherhood there are also some very basic elements that strongly

influence women's experiences of this phenomenon. The first of these critical underpinnings to be explored is women's physical wellbeing.

Physical Wellbeing

The physical wellbeing of women may impact on their experience of motherhood. Physical health of expectant and new mothers is generally closely observed antenatally, during labour and postnatally. Medical complications such as gestational diabetes, hypertension, preeclampsia, haemorrhage, anaemia and infections are all monitored and treated to maximise maternal health (Fraser & Cooper 2009). However there is a growing body of literature addressing issues of maternal physical wellbeing and morbidity that suggests aspects of maternal physical health after childbirth may not be addressed as well as is generally believed. (Cheng & Li 2008; Brown, Lumley, McDonald & Kastev 2006; Ansara, Cohen, Gallop, Kung & Schei 2005; Brown & Lumley 1998).

For instance, a Victorian population based study by Brown and Lumley (1998) investigated the prevalence of maternal physical and emotional health problems six to seven months after childbirth. This research involved a statewide postal survey of women giving birth in a two week period in Victoria Australia, excluding women who had experienced a known stillbirth or neonatal death. This study found that ninety four per cent of women reported one or more health problems in the first six months after birth (Brown & Lumley 1998). The most common health issues were tiredness (69 per cent), pain from caesarean wounds or perineal injury (60 per cent), and backache (43 per cent). Other issues included sexual problems (26 per cent), haemorrhoids (24 per cent), depression (19 per cent), relationship issues with a partner (18 per cent), bowel problems (12 per cent) and urinary incontinence (10 per cent). Most of the health problems indicated were equally common for first time mothers and mothers with two or three other children. Perineal pain and sexual problems were however more common among first time mothers (Brown & Lumley 1998). These findings have been followed up and confirmed in later research (Brown et al. 2006; Ansara et al. 2005).

Brown and Lumley's study also found that women having an instrumental birth with forceps or ventouse had the highest rates of maternal morbidity (1998). These differences remained significant after statistical adjustments were made for length of labour, infant birth weight and perineal trauma. Brown and Lumley noted that women having an assisted birth were five times as likely to report perineal pain compared to those having a spontaneous vaginal birth and twice as likely to report sexual problems, urinary incontinence, bowel problems and haemorrhoids (Brown and Lumley 1998). In addition, women who had an episiotomy had nearly a two fold increase in likelihood of reporting perineal pain compared with those women having a tear that required stitches. Perineal pain and sexual problems were also reported in an integrative review of research by Cheng and Li (2008), however, these authors noted that urinary incontinence and bowel problems were less of an issue.

The main conclusion of Brown and Lumley's study (1998) was that physical and emotional health problems are common after childbirth and are frequently not reported to health professionals. Alarmingly, a quarter of women participating in the study stated they had not talked to their health professional about their own health since the birth. Half of the women reporting health problems, however, said they would have liked more advice or help relating to their own recovery since the birth (Brown & Lumley 1998). The most frequently mentioned issues related to emotional well being (27 per cent), general health and recovery (14 per cent), tiredness (14 per cent), and breastfeeding (7 per cent). Other problems women identified as desiring help with included sexual issues, weight loss or weight gain, perineum pain, pain from Caesarean wound, nipple or vaginal thrush, bleeding, backache, relationship issues and sexual issues (Brown & Lumley 1998). It is noted that while serious maternal physical morbidity such as eclampsia, third degree tears, and postpartum haemorrhage are well detailed in obstetric books (Fraser & Cooper 2009), they are relatively uncommon conditions (Brown & Lumley 1998). In contrast common health and emotional problems following childbirth are often not discussed with health workers (Brown & Lumley1998).

This study by Brown and Lumley (1998) is significant as it highlighted the extent of unreported maternal morbidity after childbirth. The study adds to the body of growing literature that highlights common but often under-reported and under-recognised health problems following childbirth. The findings of this landmark study have been replicated in work by Brown et al. (2006), Ansara et al. (2005), Cheng and Li (2008) and Chien, Tai, Hwang and Huang (2009). Many of the common health concerns occurring after childbirth (depression, perineal pain, urinary incontinence, sexual problems, relationship difficulties, depression) are sensitive issues that may be difficult for women to disclose (Brown and Lumley 1998).

Psychological and Emotional Wellbeing

The psychological and emotional aspects of motherhood have been explored in the literature and also add to the body of knowledge concerning motherhood. There has been a shift in conceptualizations of motherhood from the perspective of the child and relationships with the child, to motherhood being viewed in terms of the experience of the woman (Squire 2009; Barlow & Cairns 1997). This aspect of the literature includes issues such as the women's experiences of maternity services, adjustment to motherhood, motherhood as a psychological process, postnatal depression and silence about the negative aspects of mothering (Brown, Davey & Bruinsma 2005; Nelson 2003; Barlow & Cairns 1997; Maushart 1997).

Early classic work on the social and emotional aspects of motherhood was undertaken by Oakley whose research explored the sociology and medicalisation of motherhood (1979, 1980, 1984). Although this research was conducted more than thirty years ago, it has since been extended at least in part by researchers such as Brown, Lumley, Small and Astbury (1994), Le Blanc (1999) and Nelson (2003).

Further Australian research by Brown et al. (1994) explored the emotional wellbeing of new mothers. In this study the researchers identified that women were often critical and

ambivalent in their own efforts of being mothers and most women found motherhood harder than they anticipated (1994). The authors noted a 'reluctance by women themselves to discuss the emotional impact of motherhood' (Brown et al. 1994:161). While women interviewed placed a high value on the work of mothering, they were aware that the process of becoming mothers had produced an irreversible change in their lives and their sense of self (Brown et al. 1994). A major finding of this study was that 'women's voices were missing from the discourse on motherhood' (Brown et al. 1994:61). The study broke new ground in its findings and significantly raised awareness about women's experiences of motherhood. An unfortunate limitation of the study was that questionnaires were distributed 8-9 months after participants gave birth which meant that less rich descriptions and less accurate reporting of early mother experiences may have occurred than if women's accounts of early motherhood were given around the time of birth.

In other work, the mood and adjustment during the transition to parenthood for both partners has been examined (Morse, Buist and Durkin 2000). The objective of this study was to examine influences that shape and determine the couple's experience from mid pregnancy to four months after the birth. This longitudinal study involved healthy pregnant first-time mothers aged 20-45 years and their partners. The method involved an initial semi structured interview and a range of questionnaires at key times, administered by post. Established tools were used to examine constructs such as anxiety, anger, depression, gender role stress and social support (Morse et al. 2000). For example, the study used the Edinburgh Postnatal Depression scale (EPDS) to identify women and men experiencing distress. The results showed that approximately 19.5 to 21.6 per cent of women were identified as distressed at three key periods between mid pregnancy and one month after birth. At four months after birth the level of women distressed had declined to 13.9 per cent (Morse et al. 2000). The study also found that anger and anxiety levels were higher at each measuring time for those identified as distressed. (Morse et al. 2000).

The findings during mid pregnancy found that women's depressed mood was related to younger age (20-24 years), less support from her partner, low scores in relationship quality, high anxiety and anger, and the male partner having high gender role stress scores for

'performance failure'(Morse et al. 2000:114). Postnatally, female distress was linked very significantly with the situation of the male partner. Predictors of female distress postnatally were the male partner working full time and being over the median age of 31 years, plus anxiety and negative affect in the male partner late in pregnancy. Low emotional support from friends and low scores on dyadic adjustment were other factors for female distress postnatally (Morse et al. 2000).

Further research exploring the psychological experience of mothering was undertaken by Barlow and Cairnes (1997). This research involved in depth unstructured interviews with participants about their mothering experience. Each interview began with the statement: 'Starting where you like, what has this mothering experience been like for you?'

This study produced a grounded theory comprising two dimensions: 'engagement', which coincides with the first year of mothering; and 'immersion' which represents the ongoing mothering experience (Barlow & Cairns 1997:235-236). Engagement involves 'establishing the intention to mother, encountering ghosts of mothering received, committing to new life circumstances, and engaging in a process of self socialisation' (Barlow & Cairns 1997:236-239). Immersion was identified as involving 'renegotiating relationships, preserving the child and preserving self, self-constructed mothering, and replenishment' (Barlow & Cairns 1997:239-242). The study concluded that mothering is a process of continuous personal reevaluation that offers women many opportunities for personal change, growth and development. However, the researchers also comment on western society's tradition of 'silencing mothers' and how women are 'reluctant to voice negative aspects of mothering as such a discussion would undermine one of their few legitimate roles' (Barlow & Cairns 1997:244-5). A limitation of the study was that it attempted to reflect on the huge range of experience that mothers of 2-12 year olds would have encountered. In addition, the researchers themselves identify a limitation of their research was that the research focused on mothers who were engaged in positive mothering behaviour and did not include any negative cases (Barlow & Cairnes), but do not define these terms. Like other research undertaken in the area of early motherhood this study investigated the experience of mothers of older children.

The Link Between Maternal Health And Infant Wellbeing

This discussion of health and wellbeing aspects of motherhood would be incomplete without discussion of the child. The symbiotic relationship of the mother and child during pregnancy, and the intense interconnectedness of the mother-baby dyad after birth make the issue of infant health and wellbeing a fundamental part of the discussion of maternal health and wellbeing.

Attachment research indicates that the quality of the infant - caregiver relationships can be both a protective factor and a risk factor for infant wellbeing **(**Arney & Scott 2010**;** Goldberg 2000). Neurobiology and brain research have established that the quality of the emotional relationship between an infant and his/her primary caregivers directly influence brain growth and development (McCain & Mustard 2002). Mares et al. explain that 'development proceeds as a complex series of interactions between the innate qualities of infants, their experience in interaction with their physical and social world, and their capacity to influence and change their environment' (Mares et el. 2011:4). However, they caution that the relationship between early experience and infant outcome is not a simple linear one (Mares et al. 2011).

Research has highlighted critical periods of brain development where crucial experiences are needed for development during infancy (Arney & Scott 2010). The formation of neural connections and the delineation of neural pathways occur as a response to stimulation from the environment. The experience of sights, sounds, languages, and eye contact help the brain's connections occur (Santrock 2010*).* During the infant period the rapid development of the brain involves the production and proliferation of synapses and repeated activation stabilises and strengthens connections between neurons and areas of the brain (Mares et al. 2011). Unused synapses are later pruned and replaced by other pathways or disappear (Santrock 2010). Neurological development is seen as a dynamic process, the rapid rate of growth in the infant period is crucial in developing both the structure and later function of

the brain (Mares et al. 2011). Arney and Scott (2010) explain that neurobiology and brain research in infant mental health focuses on the role of the social environment and attachment relationship in facilitating optimal neurological development.

These new findings are critically important in terms of women's experiences of early motherhood as mothers are usually the main caregivers for infants. The link between the physical wellbeing of mothers and their babies has been established for some time *(*Mares 2011). This new research has significant implications for maternal and child health as it stresses the importance of a mother and child establishing a warm emotional relationship for the optimal neurological and social development of the child, with serious consequences where this does not occur (Arney & Scott 2010). This is a crucial development in research and underpins the importance of motherhood in our contemporary society.

The Experience of the Transition to Motherhood

Women's experiences of the transition to motherhood have been explored in studies undertaken in a number of western countries (Miller 2005; Nelson 2003, Borjesson, Paperin & Lindell (2003), Brown & Lumley 1998). Themes present in the literature are concerned with issues such as the conflict between expectations and experiences, loss of confidence, loss of control, support needs and motherhood as a process of development. This section of the literature review will explore the issue of transition to motherhood with a focus on these themes.

First time mothers' experiences of early motherhood were explored in a grounded theory study (Barclay et al. 1997). This research sought to identify 'normal' experiences of motherhood in order to recognise and manage problems. Focus groups were used to stimulate discussion about childbirth and early motherhood, with questions: 'What was it like for you after the birth?' and 'What is it like now?' (Barclay et al.1997:720). One of the key conclusions from this study was that the experience of becoming a mother is a developmental process that seems to correspond to a chronology related to increasing

maternal confidence and experience (Barclay et al.1997). For most women becoming a mother caused them to feel 'isolated, alone and depleted rather than nurtured and supported' (Barclay et al.1997:727).

Another key finding of the study was that nursing and sociological research lacks a framework that draws together women's experiences of early motherhood. Barclay et al. (1997) argue that such a framework is needed to conceptualise the enormity of the change involved in new motherhood and provide strategies to help women negotiate this experience. The central finding of the research was that while 'birth determines motherhood in the biological sense…, in the emotional and personal sense becoming a mother takes time' (Barclay et al. 1997:725).

While this research contributed significantly to the literature concerning early motherhood, the study does have some limitations. The mean age of participants was 30.5 years, which is older than many first time mothers at the time of the research. While the mean age of infants at the time of the focus groups was 11.8 weeks, the range was between 2 to 26 weeks, resulting in a wide spread of maternal and mothering experience. Nevertheless, as a contemporary Australian study this research does contribute to the body of knowledge concerning women's experiences of mothering after the early motherhood postnatal period.

Women's experiences of the transition to first time motherhood were also explored in research by sociologist Tina Miller (Miller 2005). Miller drew heavily on women's own accounts of their experiences of pregnancy, birth and early motherhood. The longitudinal nature of the project mirrored the transition to motherhood with fluidity that a single interview would not have achieved (Miller 2005). Interviews were arranged when women were 7-8 months pregnant, 6-8 weeks and 8-9 months after birth. Participants were recruited via the snowballing technique. Despite this being a quite homogeneous group of white, partnered women, the data revealed diverse and complex experiences in the transition to motherhood.

Findings from Miller's antenatal interviews emphasised different strands of official and unofficial discourses on motherhood (2007). Many women marveled at nature and natural instincts while others intended on fully utilising technology and medical expertise. Some spoke openly about the physical changes of pregnancy being a 'shock' and the difficulty of 'something else' taking over the body and having to change their whole way of life (Miller 2007:345-346). Women shared uncertainty about their ability to care for the baby; others contemplated learning to become a mother taking a little time (Miller 2007). Despite this, Miller found that women strove to demonstrate that they are and intend to continue mothering the correct way. The notion of being a 'good mother' and mothering the 'correct way' are ideas that permeate women's hopes and expectations for the experience of early motherhood. Miller explains that women's experiences of motherhood are generally framed in terms of the medical discourse or the natural childbirth discourses which are underpinned by typecasts of the 'good mother'. In her research preparing for motherhood involved anticipating the responsibilities of motherhood and 'doing things right' (Miller 2007:346).

The concept of the 'good mother' has been explored by Brown, Small and Lumley (1997). In their research most women described a good mother in terms of being patient, caring, loving, calm, responsive, spending time with her children and fostering their emotional development (Brown et al.). Many women reported struggling to balance care for their children with transporting children to kindergarten and health appointments and getting the range of housework, cooking and shopping tasks done (Brown et al.) These authors found that although women recognised the impossible idealism of being a 'good mother' all of them worked hard to live up to this ideal. Alternate notions of the 'good-enough mother' and the 'ordinary devoted mother' had been proposed by Winnicott (1949, 1973, 1987). These terms refer to a mother being sufficiently physically and emotionally attuned to her baby and adapting appropriately to her baby at different stages to facilitate a suitable environment for healthy development (Winnicott 1949, 1973, 1987). This is a realistic alternative to the idea of the 'good' or perfect mother.

In Miller's study (2007) the childbirth and early motherhood experience of participants clashed with their expectations. For instance, women generally thought their bodies would handle birth naturally without the need for medical intervention. Women expressed a sense of loss of control and failure at not being able to achieve this. They also expressed shock at the pain they experienced during childbirth (Miller 2007). These findings were also noted by Cronin in her research with first time mothers (2003). Miller (2007) reported that in mothering their new baby participants tried to present a picture of coping as a mother, however most women did not experience being a mother as natural and innate. Similarly, Sheeran reported in a study of early motherhood that one third of participants acknowledged finding it difficult to cope with the changes associated with having a new baby, with 20 percent describing feeling overloaded, stressed or not coping some months later (Sheeran 1997). Miller went on to reveal that women discussed feeling a responsibility for their child, but also confusion due to conflict between their expectations and their experiences (2007). In addition, Miller found women slowly became more skilled at recognising and meeting their baby's needs. These growing skills were paralleled to increasing confidence in their maternal ability; however this was a lonely struggle for many (Miller 2007). The findings mirror the work undertaken by Barclay et al. (1997).

In Miller's third interviews around 8-9 months after birth participants revealed a greater sense of confidence and belief in their mothering capabilities. The transition to motherhood for many of the women was a lonely, bewildering and difficult learning experience (Miller 2007). Some women were surprised at the extent to which becoming a mother changed their life. The process of transition was acknowledged and over time most women developed a relationship with their child and became adept at recognising and supplying their child's needs (Miller 2007). At this nine month period women felt more confident, but also felt that caring for their child was easier as the child was not as fragile (Miller 2007). As women grew able to make sense of their motherhood experience, they also became more able to question the stereotypes of the good mother, rather than conform to them (Miller 2007).

This work by Miller is supported by Murphy who depicted the transition to motherhood as a sometimes 'seismic transformation' in a woman's life (Murphy 2005). Murphy described a paradoxical conflict between women being excited about their pregnancy and motherhood and giving up the image of themselves they had worked to create. For some women early pregnancy can be very difficult emotionally as they contend with lack of control and anticipate loss. These difficulties might revolve around their physical body, career, and changes in relationships (2005). Some women reflect on the type of person they want to be for their baby. Others focus on improving their behaviour such as being more poised, more grown up, or not swearing. While some women were ambivalent and anxious about becoming mothers, others acknowledged having elaborate images of themselves as mothers interacting with their babies (Murphy 2005).

Like Miller (2007), Murphy declared pregnancy involves 'the most dramatic changes you've ever experienced' (Murphy 2005:13). This change involves a complete transformation of the body, as women become aware of the person growing within them (2005). In a similar vein Erdrich (1995) described her personal encounter of experiencing her pregnant body as a separate place: 'I'm not me. I feel myself becoming less a person than a place, inhabited, a foreign land.' This sense of loss of control of their own bodies is also experienced by some pregnant women as they go through morning sickness, fatigue, hormonal changes and sore breasts (Murphy 2005). Nevertheless positive physical changes noticed by some women during pregnancy include feeling energised and having beautiful skin.

Contemporary nursing literature on motherhood has been enhanced by work undertaken by Nelson (2003). This research comprised a metasynthesis of nine qualitative studies concerning the transition to motherhood. Nelson believed that the four grounded theory studies contributed to the understanding of the many processes involved in the transition to motherhood. These processes then were confirmed and more fully illuminated by the five phenomenological studies. Most participants in these studies were first time-mothers recruited late pregnancy or early postnatally although some studies included multiparous women (Nelson 2003). Studies were either longitudinal or retrospective. The key finding of

the research was that there were two social processes identified in maternal transition, 'engagement' and 'growth and transformation'. Engagement emerged as the primary social process through which the secondary, but often simultaneous process of growth and transformation occurred (Nelson 2003).

As part of the synthesis this work identified five categories in the transition to motherhood (Nelson 2003). The first category was 'commitment' which for many women involved planning the pregnancy. For women with an unplanned pregnancy this involved making a decision to continue with the pregnancy. In the next category 'daily life,' learning mothering and the use of role models were key themes. The third category was 'relationships' which involved themes of adapting to a changed relationship with their partner, family and friends. 'Work' was the fourth category (Nelson 2003). Decision making around the return to work caused great conflict, ambivalence and anxiety. As women became mothers many made significant changes in their work life such as leaving work completely, changing from full time to part time or modifying career goals. The final thematic category of 'self' involved women reflecting on their own experience of being mothered while anticipating their new role and using strategies to address any negative aspects. This also involved introspection and self-evaluation, which were identified as inherent in the transition to motherhood (Nelson 2003).

In summary, Nelson determined that early motherhood was characterised by clashing emotions including intense love, pride, joy, excitement, fear, frustration, tension, shock, guilt, uncertainty, helplessness, confusion and loneliness (2003). Time and experience were needed to increase maternal confidence (Nelson 2003). Nelson concluded that women were overwhelmed and largely unprepared for the transition to motherhood, despite efforts at preparation. Finally, the researcher also identified that while there are many common components to the transition to motherhood the transition is not experienced in the same way by all mothers**.** This metasynthesis permitted a broader interpretive understanding to emerge than would have been possible if a single study was undertaken (Nelson 2003).

Functional Status and Support

It is clear from the literature that the women's experience of the transition to motherhood is influenced by the level of support available (McVeigh 2000; Borjesson, Paperin & Lindell 2003; Cronin 2003). Research by McVeigh (2000), for example, explored the relationship between satisfaction with social support and functional status after childbirth. The study used an inventory of functional status after childbirth (IFSAC) to assess social aspects of recovery at this time. The tool included household responsibility, self-care, infant care, return to work and social and community involvement, and return to work (McVeigh 2000). During the first six months postpartum, functional status after childbirth increased significantly. McVeigh argued that this upholds the belief that return to full functional status takes longer than physiological recovery and usually occurs gradually over an extended period (McVeigh 2000). In addition, the study found that while most participants were satisfied with initial support at the 6 week stage, there were significant decreases in satisfaction with support during the first six months from both partners and others (McVeigh 2000). Sheeran (1997) found that factors commonly identified by women as influencing their experience of being mothers included support, particularly partner support, followed by family and the maternal and child health service.

Further research concerning support needs of expectant and new mothers in the first year was undertaken by Borjesson et al. (2003). This Swedish population based study (N=196) involved a postal questionnaire that sought both quantitative and qualitative data. The study found that during pregnancy women reported sharing their thoughts and concerns about motherhood and their pregnancy with someone. Most talked with their partner (85 per cent), 49 per cent with a woman friend and 51 percent with a midwife at the antenatal clinic, who in turn provided support (Borjesson et al. 2003).

In this study Borjesson et al. (2003) documented that during their child's first year most mothers reported feeling worried or sad at some time. Thirty five per cent of women said they felt lonely and some articulated this as wanting to speak with '…someone who is in

the same situation as me' (Borjesson et al. 2003:592). The majority of mothers (85 per cent) stated they received the best support from their husbands (Borjesson et al. 2003). This contrasts with findings by Cronin (2003:263) where the maternal mother was identified as the key support in providing direct childcare, advice, emotional help, and support for new mothers to have a break or continue at school (Cronin 2003).

Furthermore, almost half the mothers in the Borjesson et al. study (2003) reported having concerns and worry about issues such as bereavement, illness, separation, or relationships that were not related to the child (2003). Most women (82 per cent) said they had talked with their husband about this, and 10 per cent reported speaking with someone else, such as a psychologist or family member (Borjesson et al. 2003). Similarly, Cronin's research identified psychological issues described by first time mothers, such as loneliness and maternal depression (2003). However additional issues identified in Cronin's cohort were inadequate accommodation space, and relinquishing baby care to return to school or work (Cronin 2003).

Other areas where women identified they needed support were those of breast feeding and infant care. In Borjesson's study, for example, many women (64 per cent) said they needed advice and support concerning breastfeeding, infant sleeping and crying (2003). While most women (83 per cent) received support from child health clinics, others received support from their own mothers (37 per cent), or women friends (36 per cent) or husbands (26 per cent) (Borjesson et al. 2003). These researchers also asked women if a person close to them made them feel like a good mother. Most women commented that their husbands did so (83 per cent), while about half said they also received encouragement from their own mother (49 per cent). Five per cent of women stated they had no one who made them feel like a good mother (Borjesson et al. 2003). The main finding of the study was that it was important for expectant and new mothers to be affirmed in their mothering role.

Phenomenological Studies

The transition to motherhood of first time mothers was explored in a Canadian phenomenological study and doctoral dissertation completed by Cudmore (1997). This thesis used Giorgi's method. The research questions underpinning this study were: 'What is the experience of being a mother like for you?' and 'How has being a mother affected your life?' (Cudmore 1997:47). The main conclusions from the research were that the meaning structure of new motherhood included three interrelated dimensions (Cudmore 1997). The emergence of a profoundly close relationship with the baby was the first dimension. This dimension involved a shared emotional world, a deep need to protect the baby from harm, and a sense of responsibility and commitment, and feeling captivated by the baby. Another dimension to the experience of being a mother involved living with one's child as an enduring presence in both presence and absence, and experiencing the self as second to the baby. The final dimension identified by Cudmore's analysis was that of experiencing an expanding sense of interrelatedness that involves feeling closeness in the mother's other relationships.

Cudmore's research findings add to the body of knowledge concerning early motherhood and enhance understanding of what it means to be a mother. The research design involved participants providing a written description of their experience of being a mother 10-11 weeks after giving birth with a follow up single in depth interview when their infants were 11-12 weeks. Whilst the study was conducted at this time after birth, the study did explore the question of women's immediate and intimate experiences of early motherhood during late pregnancy, childbirth and the early puerperium and if these change over the initial weeks of new motherhood. However, as this is Canadian based research it may not reflect women's experiences in Australia.

Similarly, Bergum completed a phenomenological study on the transformative experience of childbirth. This doctoral research used van Manen's phenomenological approach to explore the question: 'How does the experience of childbirth transform woman to mother?'

(Bergum 1986:38). In contrast to Cudmore, Bergman followed her participants intensively from mid pregnancy to a number of months after the child's birth, meeting each of them five to seven times. Bergman used the term 'conversations' to describe her meetings with the participants rather than interview as it described the actual process used.

Bergum concluded in her research that being a mother is a matter that extends beyond the mother role and the role of caring for a child and that it is 'a changed understanding of who we are, as mothers' (Bergum 1986:176). Being a mother transcends maternal and developmental tasks, stressors and satisfactions, to be a realisation and acceptance that 'I *am* a mother' (Bergum 1986:176). In some sense the question of how one can understand the transformation from woman to mother still remained as like all questions of this nature it is ongoing (Bergum 1986).

This dissertation concluded with a number of theses. Firstly, that the decision to become a mother is complex, it involves entering a change that is not really able to be comprehended and assumes a new responsibility for the world as a good place for children (Bergum 1986). This also recognises that childbirth is a sexual experience, which extends from conception throughout pregnancy, birth and infant feeding. A second thesis is that the presence of the child in the pregnant woman's body needs to be venerated during pregnancy and birth, so the woman can experience her own change during the unique relationship (Bergum 1986). The pregnant woman continues with her usual life activities but is simultaneously growing with her developing child and is altered by the presence of the child. Bergum affirms that an expectant woman experiences a changed approach to the world and reasons that becoming a mother begins with this changed view of the world (1986).

Several theses presented in Bergum's dissertation relate to the process of childbirth (Bergum 1986). Bergum concluded that the pain of childbirth is different to the pain of illness as it produces a child. Women need to be supported to cope with their pain by having familiar people and objects with them, finding comfortable positions, making noise, as well as using medications. The separation of the mother and child that happens with childbirth enables both the mother and child to be whole, but is also a process that is

probably never fully completed (1986). This research asserts that being a mother involves having one's child on one's mind (Bergum 1986). To have a child in one's life compels one to reflect on how one should be in this world and means that 'one is no longer able to live simply for oneself' (Bergum 1986:183). Women need to be supported so they can care for their children in the best possible manner. The overarching final thesis avowed by Bergum is that giving birth is a 'transformative experience' (1986:181). Childbirth transforms women and planning for the wellbeing of the mother and child needs to include and value the women's experience of becoming a mother (Bergum1986).

Bergum's thesis used a hermeneutic phenomenological approach and critically engaged with the conversation transcripts, childbirth literature, phenomenological writing and artistic sources (Bergum 1986). The theoretical framework produced rich descriptions that enhance understanding of the lived experience of motherhood and the transformation from woman to mother. As a longitudinal study it also offered insights into motherhood as an evolving and unfolding experience. However, this study was completed in Canada 25 years ago so it does not directly add to knowledge concerning women's experiences of early motherhood in contemporary Australia.

First time parents intimate relationships

Another perspective on the experience of early motherhood is offered by a phenomenological study by Ahlborg and Strandmark (2001). Their research explored first-time parents' experience of their intimate relationship, focusing on their mental health. This Swedish study used Giorgi's descriptive phenomenological method and involved ten first time parents (five couples) recruited from five different family health centers across Sweden. Each parent was interviewed individually; firstly when the child was six months of age, and again when the child was 18 months of age (Ahlborg & Strandmark 2001). During the interviews parents were asked to describe as spontaneously as possible how they experienced their intimate relationship as first time parents.

The essence of the phenomenon found in Ahlborg and Strandmark's (2001) study was that the baby became the focus of attention. All parents reported that everyday life had changed: they had less time for each other, felt less free as individuals, been less able to act spontaneously and that the relationship was influenced by the baby (Ahlborg and Strandmark (2001). While this was expected to some extent by the parents, this reduced time for each other made it more difficult to sustain the roles of husband and wife within the relationship. Lack of sleep as a result of responding to the baby's needs was a common strain with some irritation between spouses because of tiredness.

Ahlborg and Strandmark observed that the baby being the focus of attention had different meanings for different couples. Where the baby was the focus of mutual attention parents felt that this fostered their relationship. These couples' relationships featured good communication between the spouses and the strain on the relationship was only mild (some tiredness and irritability) (Ahlborg and Strandmark 2001). Where the baby received attention at the expense of the father he felt emotionally rejected and there was severe strain on the relationship. This was characterized by fatigue, severe irritation, conflict and insufficient communication (Ahlborg and Strandmark 2001).

In addition Ahlborg and Strandmark (2001) found that four out of five women did not have any sexual desire six months after childbirth. Some participants spoke of tiredness and falling into bed early every night, while another woman spoke of avoiding demonstrating too much feeling in case her partner thought she might want to make love (Ahlborg and Strandmark 2001). The authors concluded that there may be conflict between new mothers' feelings toward the baby and her feelings toward her partner and that maintaining a healthy relationship while focusing on a new baby requires good communication, exchange of tenderness and receiving emotional confirmation.

This section has reviewed some of the phenomenological studies that have explored women's experiences of early motherhood, highlighting key findings and identifying gaps in the literature. The final part of this chapter will consider existing theories of early motherhood.

Theories of Motherhood

Four theories of motherhood are noted in the literature and will be considered here in the context of understanding what it means to be a mother. These involve the work of Rubin (1961a, 1961b, 1964, 1967a, 1967b, 1975, 1977, 1984), Mercer (1981, 1985), Rogan, Schmied, Barclay, Everitt and Willey (1997) and Stern (1998).

Rubin and Developmental Tasks of Early Motherhood

Rubin undertook extensive research into early motherhood during the 1960s (Rubin 1961a, 1961b, 1964, 1967a, 1967b). This work by Rubin conceptualised the changes experienced by women during pregnancy and childbirth as a series of developmental tasks through which women progressed. Thus Rubin developed the transition to motherhood theory. This transition to motherhood was perceived to be a process that comprised mimicry, fantasy and grief work and ultimately achieved maternal identity (1967a, 1967b). Rubin considered that while the physical aspects of childbearing influenced women's experience of the transition to early motherhood it was quintessentially a cognitive reorientation process.

As part of her theory Rubin identified the tasks of pregnancy and the first few months after birth as:

1. Making and keeping the infant and self safe,
2. Ensuring the infant is accepted by the family or significant others,
3. Focusing on meeting the demands of pregnancy and motherhood, and
4. Developing an attachment relationship with the infant and later differentiating oneself from the infant (1975).

Mercer and Maternal Role Attainment

Research by Mercer (a former student of Rubin) on maternal role attainment built on and extended Rubin's work. Mercer's work concentrated on the developmental pathway to achieving maternal identity through 'maternal role attainment' (Mercer 1981, 1985). Mercer viewed development of the maternal role as being a specific cognitive process that was contingent on the women's ability to gather information, problem solve, communicate and build nurturing relationships (Mercer 1985). The stages in the process of maternal role attainment were identified by Mercer as:

1. Anticipation and visualisation of the role,
2. Formal realisation of the role with help from health professionals,
3. Informal but attentive contemplation of goals (past and future) regarding congruence with the role, and
4. Maternal role fits comfortably with other roles and within the woman herself. (Mercer 1985).

In 2004 Mercer replaced the term 'maternal role attainment' with the concept of 'becoming a mother' (Mercer 2004:228). While this modification is less rigid and less directive, the core concept 'becoming a mother' is still centred on a tiered transition to maternal identity (Mercer 2004).

Rogan, Schmied, Barclay, Everitt and Wyllie and Becoming a Mother

A fresh theory of early motherhood was developed by Rogan et al. (1997) using grounded theory research. In this work becoming a mother was identified as the core category of the change process women experience during early motherhood. In becoming a mother women transition from being overwhelmed by the dramatic changes in their life and a disturbed sense of self as they encounter new and unanticipated challenges to reach a state of feeling

in ‘a certain tune’ with their baby (Rogan et al. 1997). The change process featured the realisation of being the primary caregiver, constant responsibility and uncertainty about what to do or how to do it. The process of becoming a mother was characterised by fatigue, isolation and a sense of loss, and progressed until the women reached a state of feeling in ‘a certain tune’ with the baby (Rogan et al. 1997:877). This research and theory is significant as the experience of first time mothers is rarely studied from the perspective of women themselves (Everitt, Schmied, Rogan, Willie & Barclay 1993; Brown et al. 1994). However while this is a robust study, it is now 14 years old. In addition it focused on a later period of early motherhood with participants being an average of 11.8 weeks postpartum with infants ranging from 2 weeks to 26 weeks of age, when transition issues would be fading and less acute. This emphasizes the need for qualitative research into early motherhood from the perspective of women. The work also indicates the need for a prospective study that can give voice to women’s lived experiences of early motherhood.

Stern and the Motherhood Constellation

A fourth theory of motherhood has been developed by Stern (1998), and is called the motherhood constellation. This motherhood theory involves women developing a new mindset during pregnancy that has a variable duration but which can last for months or years. The motherhood constellation is a unique but independent construction that is ‘entirely normal’ (Stern 1998:171). This theory involves the mother’s sense of self being organized around her infant and his or her wellbeing, and her preoccupation with her relationship with her baby and his/her protection.

Work by Stern (1998) identified three preoccupations and discourses with which the motherhood constellation is concerned. These are the mother’s discourse with her own motherhood (and particularly how she experienced her mothering as a child); her discourse with herself as a mother and her discourse with her baby. The mother is focused on this

motherhood trilogy as it requires the most significant amount of mental work and mental reworking (Stern 1998).

In becoming a mother herself the woman experiences a major realignment of interests and concerns. Stern (1998) described this as an increased interest in her mother and women generally and reduced concern with her father and men. Her interest in her mother is heightened while her concern with her mother as a woman declines. Stern further adds that in becoming a mother women become concerned with their husbands as a co-parent and father for her baby and less as a man and sexual partner. Stern argues that a new triad has been formed, the maternal –grandmother – mother-baby.

Stern has outlined a number of themes the women may experience as the motherhood constellation. (1998). The first theme is the 'life growth theme', where the woman questions if she can maintain the life and growth of the baby. The second theme is termed 'primary relatedness' and here the woman wonders if she can emotionally engage with her baby and facilitate his/her emotional development. The next theme is the 'supporting matrix' theme. This involves the woman considering if she will know how to create the necessary support system to fulfill these functions. The final theme is 'identity organisation', which involves the woman wondering if she can transfer her self-identity to permit and facilitate these functions (Stern 1998). While Stern acknowledges that there are psychobiological and hormonal factors that influence the development of the motherhood constellation, he holds that social and cultural conditions have the major role in the establishment of the motherhood constellation (1998).

The transition to motherhood theories have been critiqued by Parratt and Fahy (2010) who argue that the theories of Rubin and Mercer are baby centric nursing theories instead of women centred theories. They argue that consequently the theories are inconsistent with contemporary midwifery. Furthermore, they reason that the theories of early motherhood continue to be too simplistic and overlook the intricacy and complexity of women's lived experience of early motherhood (Parratt & Fahy 2010). The motherhood constellation theory of Stern contrasted with the theories of Rubin and Mercer in being more woman

centred. This theory also has greater complexity in that it addressed multiple relationships and challenges confronting new mothers. The 'becoming a mother' theory of Rogan et al. is strengthened by being based on women's perspectives of the transition to motherhood and comprehensively described their experiences. Overall, these theories extend and challenge the understanding of early motherhood.

Conclusion

The major literature concerning early motherhood has been introduced and critiqued in this chapter. Representations of motherhood have been explored and the expectations versus the reality of motherhood have been discussed. Health and wellbeing aspects of motherhood were also explored as well as the emotional aspects of motherhood and the fact that many women find motherhood harder than expected. Issues of psychological and emotional well being explored in the literature include motherhood as a psychological process, adjustment to motherhood and negative aspects of mothering.

An important area impacted by the health and wellbeing aspects of motherhood is the health and wellbeing of the infant. As mothers are usually the main caregiver, women's experiences of early motherhood are very important in terms of the quality of the mother-baby attachment relationship and the subsequent development of the child. The transition to motherhood is a significant change in a women's life. The dramatic physical changes associated with pregnancy and childbirth are augmented by the social, emotional and psychological changes.

The separate areas of motherhood discussed here do not do justice to the concept of the 'lived experience of motherhood'. There is a lot of literature concerning motherhood from a quantitative perspective or focusing on medical analysis, but limited information about the lived experience of early motherhood as experienced by women themselves. While some

contemporary literature is beginning to give voice to women's experiences, generally there is a dearth of research data based on women's lived experiences of early motherhood. In particular there is only limited literature about women's experiences of early motherhood written from the perspective of midwives and maternal and child health nurses.

This research project addressed a gap in knowledge and understanding about women's experiences of early motherhood. The study aimed to explore women's experiences of early motherhood, as described by first time mothers. To facilitate a focused and in depth exploration of early motherhood the period to be studied was defined as the period between late pregnancy (34-40 weeks gestation) and 6-8 weeks after birth. As the transition to motherhood is more intense and dramatic for first time mothers, this group was selected as the target. As the research aim and question are situated in a qualitative framework exploring lived experience, phenomenology was selected as the research approach. This approach enabled women's voices to be captured in rich thick descriptions to enhance understanding of the experience of early motherhood. The next chapter will outline phenomenology as the theoretical framework of the study.

Chapter 3
van Manen's Hermeneutic Phenomenology

Introduction

The previous chapter reviewed the literature concerning motherhood and presented a rationale for undertaking this research. This chapter provides an overview of phenomenology as the theoretical framework guiding this study. Hermeneutic phenomenology as articulated by van Manen (1997) was selected as the theoretical perspective for this study. This particular approach is explored and traced to its essential underpinnings. Similarities between phenomenology and nursing and reasons for selecting this framework are also argued.

Phenomenology

Phenomenology has been discussed variously in the literature but in simple terms it is defined by Taylor, Kermode and Roberts as the study of a phenomenon or a thing (2006). It is described by Husserl as 'a new science' and the 'science of phenomena' (Husserl 1913/31:41). In contrast, Merleau-Ponty depicts phenomenology as the study of essences (1962) while Spiegelberg (1975) considers it a philosophical movement. Phenomenology is defined by Polgar and Thomas as both a method of philosophy and an approach to psychology (1995). They argue that phenomenology emphasises the 'direct study of personal experience and the understanding of human consciousness' (Polgar & Thomas 1995:110).

The purpose of phenomenology is to describe phenomenon in terms of lived experience (Streubert and Carpenter 2011). Lived experience is the 'total sphere of experiences of an individual which is circumscribed by the objects, persons and events encountered in the pursuit of the pragmatic objectives of everyday living' (Schutz 1970 cited in Streubert and

Carpenter 2011:74). Streubert and Carpenter identify phenomenology as a field of inquiry that 'cuts across philosophical, sociological, and psychological disciplines' and involves a 'rigorous, critical and systematic investigative method' (2011:72). This notion of phenomenology being both a way of thinking and a research method is important as it reflects the intertwined nature of the philosophical underpinnings and the research approach.

Phenomenology was pioneered by Edmond Husserl (1913/1931) with other philosophers such as Martin Heidegger (1962) and Maurice Merleau-Ponty (1962) further advancing the evolution of the movement. Philosophical underpinnings from these philosophers are embedded in the approach advocated by van Manen. van Manen's particular approach to phenomenology is considered next.

van Manen's Hermeneutic Phenomenology

Hermeneutics is defined by van Manen as 'the theory and practice of interpretation' (2000a, 1997:179). Early eighteenth and nineteenth century scholars such as Schleiermacher (1768-1834) and Dilthey (1833-1911) have contributed to the early literature on hermeneutics (Schleiermacher 1977; Dilthey 1985). Schleiermacher defined hermeneutics as 'the art of understanding the discourse of another person correctly' (cited in van Manen 2000b:20). His work was made known by Dilthey who published an essay on 'The Origins of Hermeneutics' in 1900 (van Manen 2000). Dilthey believed that the study of the human sciences comprised the interaction of personal experience, reflective understanding and expression in gesture, word and art (van Manen 2000b). Later scholars such as Gadamer (1976) and Ricouer (1976) coupled phenomenology with a concern for hermeneutics. The basic philosophical concern underlying these approaches is to understand the lived meaning of the life world – interpreting human experience.

Phenomenology, according to van Manen, is 'the study of phenomena, the way things appear to us in experience or consciousness' (van Manen 2000a). The term hermeneutic phenomenology is described as striving to give attention to both aspects of its nature. This

method of inquiry is descriptive as it aims to be attentive to how things appear and allow things to speak for themselves. The methodology is hermeneutic and interpretive because it asserts that 'there are no such things as uninterpreted phenomena' (van Manen 1997:180).

Hermeneutic Phenomenology: Essential Characteristics

According to van Manen, hermeneutic phenomenology is a 'human science which studies persons' (1997:6). The uniqueness of each human being is valued as incomparable, unclassifiable, and irreplaceable (van Manen 1997). van Manen noted that,

> Human science … studies 'persons' or beings that have 'consciousness' and that 'act purposefully' in and on the world by creating objects of 'meaning' that are 'expressions' of how human beings exist in the world (van Manen 1997:3-4).

The characteristics of a hermeneutic phenomenological human science have been delineated by van Manen as follows:

- the study of lived experience
- the explication of phenomena as they present themselves to consciousness
- the study of essences
- the description of the experiential meanings we live as we live them
- the human scientific study of phenomena
- the attentive practice of thoughtfulness
- a search for what it means to be human
- a poetising activity (van Manen, 1997:9-13).

These characteristics of van Manen's hermeneutic phenomenological human science will be explored with reference to their philosophical origins.

Phenomenological Research is the Study of Lived Experience

Phenomenological research focuses on lived experience. Phenomenology is the 'study of the life world', which is the world as we experience it before we reflect on it (van Manen 1997:9). This idea stems from Edmond Husserl (1970). Husserl described the life world as 'pregiven,' the world that was 'always already there, existing in advance for us' (1970:142). He also describes 'the natural primordial attitude of … original natural life' (Husserl 1970:145). Husserl uses the phrase 'natural' to depict that which is original and preceding reflection (van Manen 1997:182).

In addition, Martin Heidegger (1962), a philosopher and a student of Husserl, added a more existential aspect to the notion of life world. Heidegger considered phenomenology as the study of *being*, or the study of *ways-of-being-in-the-world* (1962). This refers to the way human beings exist, act or are involved in the world (van Manen 1997). Phenomenology therefore aspires to achieve a deeper understanding of the meaning of everyday experiences (van Manen 1997). The aim of phenomenological research is therefore to use people's experiences and reflections to gain an understanding of the significance or deeper meaning of some facet of human experience (van Manen 1997).

In order to achieve this aim, phenomenology considers the question of 'What is this (or that) experience like?' van Manen asserts phenomenology is distinguishable from other sciences as it endeavours to develop rich insightful descriptions of the way the world is experienced pre-reflectively and without classifying or theorising. Phenomenology does not offer theories or explanations; instead it offers the opportunity of insights that bring understanding and rich meaning to our experience of the world through an awakening of consciousness (van Manen 1997).

Phenomenological Research is the Explication of Phenomena as they Present Themselves to Consciousness

Phenomenology is potentially interested in anything that presents itself to consciousness. The object may be real or imaginary, empirically measurable or felt subjectively (van Manen 1997). This concept of consciousness was developed by Husserl. He asserted that in its widest connotation the term consciousness 'includes all experience,' and 'in itself has a being of its own' which is unaffected by phenomenological disconnection (Husserl 1913/1931:113; Husserl 1970:83). The notion of consciousness was further explored by Merleau-Ponty (1962). He acknowledged that 'all consciousness is consciousness of something' (Merleau-Ponty 1962:xvii). He considered consciousness to be the means through which 'a world forms itself around me and begins to exist for me' (Merleau-Ponty 1962: ix), and that consciousness gives meaning to our existence in the world.

According to van Manen consciousness involves being 'aware, in some sense, of some aspect of the world' (van Manen 1997:9). Human beings can only relate to the world through their consciousness. Things which are outside a person's consciousness are outside the boundaries of possible lived experience. Reflection on lived experience is recollective and retrospective as it is reflection on experience that has already been lived through (van Manen 1997). In addition Husserl argued that the fundamental structure of consciousness was intentionality. Intentionality involves turning to the phenomenon in a different level of consciousness as it becomes illuminating for people in different ways. (Merleau-Ponty 1962/1995).

Phenomenological Research is the Study of Essences

The term essence is described by van Manen as being 'that what makes a thing what it is' (van Manen 1997:177). The term originates from the Greek word 'ousia' meaning the inner essential nature or the true being of something (van Manen 1997). van Manen records that Husserl used the idea of essences to refer to 'the *whatness* of things, as opposed to their *thatness*' [or their existence] (1997:177). The difference referred to here can be understood

by considering the whatness is concerned with the fundamental characteristics of a phenomenon, while the thatness is concerned with the actual state in which the phenomenon occurs. Merleau-Ponty added to this concept and defined phenomenology as 'the study of essences,' reasoning that 'all problems amount to finding definitions of essences' (1962:vii). One example provided by Merleau-Ponty was the essence of perception or consciousness (Merleau-Ponty 1962).

Phenomenology therefore attempts to identify the essence of phenomena and methodically reveal and describe the meaning of lived experience. van Manen explains that phenomenology is less interested in the facts pertaining to something than the essence or nature of the experience itself. Rather, it seeks to describe and interpret the lived quality and significance of the experiential meaning of experience (van Manen 1997).

Phenomenological Research is the Description of the Experiential Meanings We Live as We Live Them

Human science is the study of meanings. This term 'human science' originates from Wilhelm Dilthey (1987). Dilthey reasoned that human phenomena and natural phenomena were different in that human phenomena needed interpretation and understanding while natural science mostly involved external observation and explanation. Dilthey notes that: 'We explain nature, humans we must understand' (cited in van Manen 1997:181). Dilthey argued that the fullness of lived experience can be captured by recreating and replicating the meaning found in human endeavor, labour and creativity (van Manen 1997).

According to van Manen, 'phenomenological human science is the study of lived or existential meanings' (1997:11). This mode of inquiry tries to describe and explain these meanings in a rich and deep way. Phenomenology differs from other social sciences as it is not focused on statistical links between variables, the prevalence of social opinions or the frequency of particular behaviours. van Manen (1997) maintains that phenomenology diverges from other disciplines as it does not intend to reveal meanings specific to other cultures such as ethnography, to certain social groups such as sociology, or to historical

periods such as history. Instead van Manen emphasizes that phenomenology endeavours to illuminate the experiential meanings as they are lived in the life world, the everyday existence (van Manen 1997).

Phenomenological Research is the Human Scientific Study of Phenomena

van Manen stresses that phenomenology is scientific as it is 'a systematic, explicit, self-critical, and intersubjective study of its subject matter, our lived experience' (van Manen 1997:11). He argues that phenomenology is systematic as it employs an orderly style of questioning, reflecting, focusing, intuiting and so on. This research approach is explicit as it tries to express the elements of meaning entrenched in lived experience. This distinguishes phenomenology from poetry or literary texts which leave the meaning implicit (van Manen 1997).

van Manen continues on to substantiate his assertions regarding phenomenology 'being a self-critical and intersubjective study of its subject matter' (1997:11). He declares that phenomenology is self-critical as it constantly scrutinizes its own aims and processes as it attempts to acknowledge its strengths and limitations. Phenomenology is also viewed as intersubjective in that the researcher needs the reader (or the other) to develop a dialogic relationship with the phenomena and therefore authenticate the phenomenon as depicted. In the tradition of Dilthey (1987) noted above, van Manen states that phenomenology is 'a human science rather than a natural science' as it explores the structures of meaning in the lived human world (van Manen 1997:11).

Phenomenological Research is the Attentive Practice of Thoughtfulness

According to van Manen 'thoughtfulness' is a single word that exemplifies phenomenology (1997:12). Renowned phenomenologists such as Heidegger (1962) described thoughtfulness as an attentive heeding or caring attunement (cited in van Manen 1997). Thoughtfulness involves a careful wondering and marveling about life and living and 'what it means to live a life' (van Manen 1997:12). van Manen notes that thoughtfulness is

present in the daily concerns of parents, teachers and childcare specialists. Phenomenological research informs the attentive consideration or thoughtfulness that is practiced in these situations. (van Manen 1997).

Phenomenological Research is a Search for what it Means to be Human

As already discussed, human science is the study of meaning, and human science research involves explicating meaning (van Manen 1997). Phenomenological research seeks to move toward a more complete understanding of what it means to live in the world, giving consideration to the historical and cultural influences that have added worth to the ways of being in the world (van Manen 1997). The crucial goal of phenomenological research is the completion of human nature, to 'become more fully who we are' (van Manen 1997:12).

Phenomenological Research is a Poetising Activity

According to Marcel (1950) phenomenology differs from other research in that the link between the research and the results cannot be severed without losing aspects of the reality of the results. van Manen notes that phenomenology is similar to poetry in that it is inappropriate to request a summary to obtain the result as this would damage the result as the poem itself is the result. Like poetry, phenomenology seeks to reveal a primal and evocative description, something Merleau-Ponty likened to involving 'the voice in an original singing of the world' (1973, cited in van Manen 1997:13). van Manen asserts that poetising is not just a type of poetry, or creating of verses. He emphasizes rather it is contemplating on original experience and expressing it in a more primordial way (van Manen 1997).

van Manen then draws on Merleau-Ponty's writings on language to contend that poetising involves using language to 'speak the world', or 'sing the world' (1997:13). He advocates engaging language in an essential invocation or poetising to attend again to the silence from which words are born. van Manen advocates searching to identify what is the essence of an

experience or phenomenon and discovering recollections that had not been considered or come to awareness previously (1997).

Summary of the Characteristics of Phenomenology

It is helpful to draw together these features of hermeneutic phenomenology as articulated by van Manen. Firstly, phenomenological research focuses on lived experience. As a result it aims to use people's experiences and reflections to gain an understanding of the significance or deeper meaning of some facet of human experience (van Manen 1997). Moreover, the core focus of phenomenological research is to explore the nature of phenomena as they present themselves to consciousness. As such, phenomenology is passionately interested in the significant world of the human being (van Manen 1997). Phenomenology also attempts to identify the essence of phenomena and systematically reveal and describe the meaning of lived experience (van Manen 1997). As a consequence, this mode of enquiry aims to interpret these meanings in a rich and deep way. In addition, phenomenological research is scientific in an expansive sense as it is orderly, explicit, reflective and self-scrutinising. As a science it is intersubjective as it requires the other to establish a dialogic relation with the phenomena. Furthermore, phenomenology is a human science as it is concerned with the meaning of the lived human world. It involves a heedful thoughtfulness as it searches for a fuller grasp of what it means to be in the world. Finally, phenomenological research is also a poetising activity as it engages language in a primal way to capture and 'sing the world' (Merleau-Ponty 1973).

This discussion has explored van Manen's hermeneutic phenomenology according to its essential characteristics. Discussion of the characteristics has included discussion of the concepts of intentionality, essence, life world, intuiting and description. A further concept worth noting is the phenomenological attitude of 'bracketing' (Welch 2011). Welch describes this as the process whereby the researcher reflects on their own personal assumptions, attitudes, biases, and beliefs regarding the phenomenon of interest, and endeavours to lay these to one side to reduce the risk of their own views influencing the research finding (2011). van Manen defines bracketing as 'the act of suspending one's

various beliefs in the reality of the natural world in order to study the essential structures of the world' (1997:175). The next section of this chapter will explore the similarities between phenomenology and nursing.

Phenomenology and Nursing

There is a need to be vigilant in the application of phenomenology to research inquiry. The question of how the essential elements of phenomenology apply to the phenomenon or topic of interest need to be explored.

Similarities between Nursing & Phenomenology

There are a number of similarities between nursing and phenomenology. Of major significance is that both are focused on exploring the life world or 'world of immediate experience' (Husserl 1970:103-186 as cited in van Manen 1997:182). Both philosophies value the uniqueness of the individual and begin with the personal subjective world. Phenomenology is well suited to investigating phenomena important to nursing as nursing practice is enmeshed in people's life experience (Streubert & Carpenter 2011).

Nursing and phenomenology are also similar in that they acknowledge the presence of multiple realities. Both view the world from an interpretative and naturalistic perspective and attempt to make sense of phenomena in terms of the meanings that people bring to them (Denzin & Lincoln 2003). Individuals participate in social actions and as a result of this come to understand phenomenon in different ways (Streubert and Carpenter 2011).

Holism is another key component of both phenomenology and nursing practice. Phenomenology and nursing view the individual as a holistic system, but one that is also 'engaged in the world of others, in interacting worlds of experience' (Munhall 2007:5). Both avoid reductionism and seek understanding. Nursing is concerned with caring for the whole person, 'sick' or well. The bio-psycho-social perspective underpins many theories of nursing. The person is viewed within the context of their relationships with others (such as

family, work or other) and nursing is focused on caring and understanding. Phenomenology is concerned with situated context, time and space considerations, and existential meaning.

Respect for the personhood of individuals is also at the core of both phenomenology and nursing philosophy. Nursing is person centred, and works in collaboration with individuals who are seen as 'patients' or 'clients' depending on the setting. Phenomenology involves engaging with individuals as 'participants', who are seen as partners in the research inquiry. Both domains encourage a collaborative relationship with the client/patient or participant. With phenomenology the researcher is part of the process, and similarly with nursing the nurse participates in a therapeutic relationship. Phenomenology values the uniqueness of the individual person, and this is manifested by rich narrative that is reported.

Phenomenology is Complementary to Nursing Practice

Phenomenology is complementary to nursing practice in that it emphasises the individual and his or her perspective on their experience. This philosophy underpins a person-centred approach to nursing care. It highlights that there are multiple realities and that it is the individual's own experience of life, health or illness that determines their interpretation of this. Phenomenology offers a respectful framework from which to interact with clients/patients, facilitating greater respect for the individual's experience.

There are several other ways in which phenomenology is complementary to nursing practice. Phenomenology is a useful conceptual lens to inform nursing practice. In addition, phenomenology offers a person-centred focus, which encourages heightened awareness and sensitivity to the individual's holistic experience. Assumptions are put aside to enable the nurse to listen attentively to the person's story. This might include a full spectrum of thoughts, feelings, bodily experiences and emotions. In a general sense the focus of nursing practice shifts from the mechanistic and medical to the individual's own perspective.

Critiques of the use of Phenomenology in Nursing Research

Although phenomenology complements nursing practice, critiques of contemporary phenomenological studies of nursing and health sciences have emerged. These focus on the charge that there is a tendency for researchers to propose phenomenological studies that focus on describing the individual's experience rather than on the phenomenon itself. Michael Crotty has contributed much critique in this area (1996). He argues against what he has termed the 'new phenomenology' which is research avowed as phenomenological but which is closer to ethnography, ethnomethodology or symbolic interactionism (Crotty 1996). Such research transforms research from a 'study of phenomena' as the immediate objects of experience into a study of 'experiencing individuals' (Crotty 1998:48). Crotty argues that instead, the focus of phenomenological research should be the experience of the phenomena being investigated rather than the individual experiencing the phenomena. This involves reflecting on our experience of 'the things themselves' and not ourselves.

This is captured by van Manen (1997) who cautions that:

> From a phenomenological point of view we are not primarily interested in the subjective experiences of our so-called subjects or informants, for the sake of being able to report on how something is seen from their particular view, perspective, or vantage point….However, the deeper goal, which is always the thrust of phenomenological research, remains oriented to asking the question of what is the nature of this phenomenon… as an essentially human experience (van Manen 1997:62).

Further critique on the shift from the essential nature of phenomenology to a concentration on the people's subjective experience is located in the works of Moustakas (1994) and Kvale (1996). Discussion about what makes phenomenological research phenomenological has been assisted by the work of Paley (1997, 1998).

The critique of phenomenological research has been furthered more recently by Norlyk and Hrder (2010). These authors undertook a systematic review of published empirical studies identified as phenomenological and undertaken in the field of nursing. The aim of their

research was to stimulate discussion concerning scientific criteria that should be adhered to prior to the publication of a study. Thirty seven phenomenological articles published in English over an 18 month period were reviewed in terms of phenomenological approach, methodology, key words, design and analysis, presentation of findings and justification of study (Norlyk & Harder, 2010). These researchers identified several problems in the phenomenological studies reviewed (Norlyk & Harder, 2010). Firstly, many study authors did not clearly articulate which phenomenological approach guided their study or the philosophical assumptions on which it was based. Norlyk and Harder's review (2010) also found that phenomenological nursing research focused on the subjective experience of the participants rather than the unfolding phenomena. This supports Crotty's argument outlined above (1998).

Additional critique offered by Norlyk and Harder (2010) concerning their systematic review was that the findings in many studies were not explicitly interrelated and the meanings not related to each other. Norlyk and Harder conclude that the variations on phenomenological approaches, inconsistencies in methods and rigour and omissions make it difficult to assess what makes a phenomenological study phenomenological. They argue that it is not appropriate to refer to phenomenology as an approach to research but that how the principles of phenomenology philosophy are implemented in a study needs to be delineated (Norlyk & Harder 2010).

Reasons for Selecting This Framework

The research question at the centre of this study was the determining factor behind the selection of phenomenology as the theoretical framework underpinning this study. It was considered important that there be congruence between the research question and the methodology. The research question aimed to explore the phenomenon of early motherhood as experienced by healthy first time mothers. As the core focus of phenomenological research is to explore the nature of a phenomenon as an essentially human experience there was a harmony between the research question and the method.

Further, the human science approach of van Manen was selected as it is 'avowedly phenomenological, hermeneutic, and semiotic or language orientated' (1997:2). This approach endeavours to give attention to both descriptions of phenomena and the interpretation of phenomena, asserting that uninterpreted phenomena do not exist (van Manen 2000a). A language orientation is essential to allow the research process of textual reflection to contribute to thoughtfulness and understanding (van Manen 1997).

Another reason for the selection of van Manen's approach to phenomenology as the theoretical basis for this study was the existential tenets identified in his work (1997). Pregnancy, childbirth and mothering are very embodied experiences. Carrying a child is a literal embodied experience. Women also experience enormous emotional and social changes during the process of becoming mothers for the first time. It was considered that van Manen's existential tenets would provide a very useful framework to reflect on women's experiences of early motherhood. van Manen's existential tenets (1997:105) are:

- Lived body (corporeality),
- Lived space (spatiality),
- Lived other,
- Lived time

According to van Manen these existentials 'can be differentiated but not separated' and they form an intricate unity that is our lived world (1997:105).

This framework of existential tenets provided a useful tool to reflect on the lived experiences women described and shared concerning early motherhood. The nature of the significant body changes associated with pregnancy, childbirth and the postnatal period have been able to be explored deeply within the concept of the 'lived body' (van Manen 1997:105). Relationships between women and their partners, women and their extended families and women and other significant people in their lives has been explored in this study, and van Manen's concept of 'lived other' (1997:104) has been useful in reflecting on themes within the data. Time and space were also experienced by women as having

different meanings during the journey to early motherhood. van Manen's existential tenets have provided a framework that has been helpful in exploring these concepts (1997).

Conclusion

This chapter has introduced phenomenology as both a philosophy and research methodology. Hermeneutic phenomenology has been identified as the theoretical framework guiding this research study. The features of van Manen's particular approach have been traced to their essential underpinnings and explored. Similarities between phenomenology and nursing and how phenomenology can be used to inform nursing have been discussed. At the same time, caution needs to be exercised to ensure that where researchers have identified a piece of work as 'phenomenological' that it has met the criteria of phenomenology in substance as well as in name. Finally, the rationale for the selection of this theoretical framework has been stated. The next chapter will introduce and detail the research design and delineate the method employed in this study.

Chapter 4

Investigating Lived Experience

Introduction

In the previous chapter van Manen's hermeneutic phenomenology was presented as the theoretical framework for this study. This research program explored the phenomenon of early motherhood. Given that the program was located in the realm of lived experience, a phenomenological approach to inquiry was employed, as detailed in the previous chapter. This chapter introduces the research design developed for this study and discusses the rationale underpinning its particular features. The methods used in the conduct of this research will be discussed along with ethical issues pertinent to the study. The chapter will conclude by addressing the issue of rigor in the study.

Discussion of Features of the Research Design

Research Aim and Research Question

The study design was developed from the aim of the research. The aim of the research was to explicate the lived experience of early motherhood. The research question that informed this research was: 'What is the lived experience of early motherhood as described by first time mothers?'

Location of Study

The research was based in a rural municipality in Victoria as this is where the researcher lives and worked. There were ethical issues associated with undertaking research in an area where the researcher worked which will be addressed later in this

chapter. It must be noted that all participants were unknown to the researcher prior to participating in the study and none were from her own maternal and child health practice.

Number of Participants

The number of participants required for qualitative studies is substantially less than those involving quantitative research where large numbers are required to determine statistical significance. In phenomenological studies the focus is on obtaining rich detailed descriptions to facilitate an in depth understanding of the phenomenon under investigation. The number of participants is not critical as the research does not seek to generalise findings (Streubert & Carpenter 2011). The decision to involve 10-15 participants in this study was based on two criteria for phenomenological research. Firstly, participants were engaged because of their lived experience with the phenomenon. Secondly that the women's accounts of their experiences of early motherhood would provide in-depth material for exploration and illumination. In total 13 first -time mothers participated in the study. This number of participants was large enough to provide some breadth of experience that was explored in the sequential in-depth interviews, and still be small enough to allow rich and deep understanding to be shared in the interviews.

Participants were recruited from two rural district hospitals when they attended antenatal clinics between 28-34 weeks gestation. As local women also attend hospitals outside the municipality for maternity care, recruitment extended through local community newspapers, newsletters and local medical centres sharing maternity care with other hospitals.

Time Period Studied

This study focused on the period of early motherhood that extends from late pregnancy until after the completion of the puerperium. For the purposes of this study

late pregnancy was defined as the period from 34 weeks of gestation until the end of the pregnancy. The question of when motherhood begins is outside the scope of this study and therefore has not been included as part of this study.

The period defined as early motherhood was essentially an arbitrary decision. The intention was to focus on the early motherhood period to capture thick descriptions and rich understandings of women's lived experience at this time. It was hoped that an intensively-focused study such as this would reveal understandings about women's lived experiences as they progress from being heavily pregnant, experiencing labour and childbirth and finally nurturing their newborn child.

Engaging Participants

Posters and pamphlets advertising the study were displayed in the antenatal clinics at two district hospitals and in six local medical centres. (see Appendix 1 and Appendix 2). A press release was also issued in the local newspapers (Appendix 3). Pregnant women interested in the research were invited to contact the researcher to express interest either via a mobile telephone number, or posting a written form attached to the advertising pamphlet. Mail for the project was received via the local post office to provide confidentiality of the researcher's address given over 400 pamphlets were distributed across the municipality. Three participants made contact to express interest at this stage. Following confirmation that respondents met the requirements of the study (first time mothers 18 years of age or over and experiencing a normal pregnancy) and expressing interest in participating in the study, they were invited to arrange a time and place to provide written consent and be interviewed.

After the initial advertising phase, weeks passed without any further expressions of interest in the project by pregnant women. It was then decided to approach the two local hospitals for permission to introduce the project to expectant couples at the antenatal classes. The hospitals approved this request and the researcher made short presentations at four separate antenatal education classes about the purpose and

nature of the project. These hospitals also granted permission for the researcher to attend the antenatal clinic sessions to discuss the project and invite women to participate. This one-to-one personal invitation approach proved to be the most successful strategy in engaging participants. It involved the researcher introducing herself as a local midwife and maternal and child health nurse, outlining the nature and purpose of the project and asking women if they were possibly interested in further information.

These different recruitment strategies resulted in 13 participants and included four women who initiated contact with the researcher to express interest in the study after reading the advertising pamphlet. Three of the women posted the expression of interest slip to the researcher and were then contacted by telephone. One participant telephoned the researcher directly to express interest in the project. Five women accepted invitations to participate in the study after being approached personally by the researcher in the antenatal clinic. A further four participants accepted invitations to participate after listening to a five minute presentation about the study made to antenatal education classes.

Overall 25 first time mothers were approached about participating in the study. Of these, seven declined to participate. Women declining invitations to participate were not asked to give any reason, although most chose to. Reasons offered by women included feeling anxious, being close to term, moving away, or simply being unsure about their ability to commit to the full duration of the study. Three women stated that they were not interested. Another five women expressed interest in participating in the study but did not commence participation. Two of these women developed hypertension and required admission to hospital prior to the first interview being conducted. Another two women arranged interview times but changed their mind before providing consent and having the first interview. A fifth woman was lost to contact as she did not respond to messages to arrange the initial interview. These details are summarised in table form in Appendix 4.

The Interview Process

The rationale for conducting interviews at three key stages was in order to capture pictures of women's experiences at different times during this transition to motherhood. Although continual observation of pregnant women from late pregnancy until after the puerperium was considered by the researcher because of the potential to provide an even more detailed picture of early motherhood, it was rejected as a pathway of inquiry due to being too intrusive for participants and not viable in terms of the time required. Selecting key stages for interviews with participants about their experiences at that time was chosen as a workable compromise. While in some sense the selection of key stages to schedule interviews was arbitrary, there were also good arguments behind the selection of these key periods. The late pregnancy interview was scheduled when the participant was within six weeks of her estimated date of confinement. Women at this stage are heavily pregnant and are also usually attentive to the upcoming birth of their baby and themselves as becoming mothers. It was felt that interviews at this stage would facilitate establishing a rapport with the participant prior to the stress of labour and birth and also capture her thoughts and experience at this time.

Two to three weeks after birth was the second key stage for interviews. This was chosen as a key stage to enable women to explore and reflect on their experience of labour, birth and early motherhood. It would perhaps have been useful to observe and interview women during labour and just after delivery, but this was considered to be too onerous for participants, as well as not being viable for the researcher. The researcher's professional experience also suggested that it would be less intrusive at such a special occasion in a family's life to allow some time before recommencing the interviews.

The final interview was undertaken between 6 to 8 weeks after childbirth. This period allowed participants and families time to progress through the early motherhood

period and to begin to integrate their new roles. In addition, this allowed each participant to explore and share her transition to motherhood and reflect on this with a greater sense of perspective. It was anticipated that there would be changes in women's experiences of motherhood as they journeyed through this early transition. The series of three interviews were designed to provide windows of opportunity to explore women's experiences of early motherhood and added fluidity to women's stories of their experiences (Miller 2005).

Participant Journal

Keeping a participant journal (diary) was mentioned on the advertising pamphlet as something that would be helpful to the study, but was not a mandatory requirement. It was considered that supplemental journal records would add another dimension and supplement the interview data about participant's experience of early motherhood. While this was viewed as a very positive addition, it was not set as a requirement of the study to avoid excluding participants who would add to the richness of the interview data but may be lost to the study if the requirement to keep a journal was compulsory.

Each participant was provided with an A5 size spiral notebook. Standard brightly coloured hard cover books were chosen to be appealing and easy to both find and use. Each notebook had a small piece of paper pasted into the front cover (see Figure 4.1 below). This insert included the project logo and the research question *'What is being a mother like for you, at this time?'* Participants were encouraged to jot down or record any thoughts related to their experience of being a mother. The participant journals were collected after the final interview, photocopied to allow collection of information, and then returned to participants to keep.

What is being a mother like for you, at this time?

Figure 4.1: Journal insert

Academic thesis writing has begun to include researcher reflection, particularly in the qualitative sphere of research (see, for example, Welch (2003)). This is important as it provides additional insights into the research. The dilemma exists about whether to have a separate dedicated reflective chapter versus 'integrated reflection' throughout the course of the thesis. In this thesis reflections will be presented in a separate chapter. This will document the journey of the researcher and highlight researcher issues, concerns, conflicts and reflections of the research experience.

Ethical Considerations

As this research study involved healthy pregnant and new mothers stringent ethical considerations were built into the research methodology.

Approval for the study was formally obtained from the RMIT University Human Research Ethics Committee in October 2004 (Appendix 5). In addition written approval and support for the study was also obtained from the Directors of Nursing of two local hospitals, the Chief Executive Officer of the rural municipality, and the six local medical centres that participated in the study (Appendix 6). Standard ethical considerations relating to informed consent, voluntary participation, anonymity,

confidentiality, storage of data and level of risk have been adhered to. These will be discussed presently.

Participant Information Sheet and Consent

Each participant was provided with written details about the research study via the Participant Information Sheet (Appendix 7). This was provided either at the time of first contact at the hospital, mailed prior to the first interview, or provided prior to obtaining consent to the interview. Prior to the initial interview women had the opportunity to read the information sheet and clarify any areas that may have been requiring clarification. Where women were interested in participating in the study they were asked to provide written informed consent. Some participant did not have any questions at all, so aspects of the research were discussed to ensure the participant was fully informed and prepared to give consent to participate in the study. Information provided to women involved the method of three audio taped interviews, freedom to withdraw at any stage, assurances of confidentiality and anonymity, secure storage of data, introduction of the journal, and the various supports available to participants if required. The researcher witnessed the provision of written consent and a photocopy of the consent form was either posted out to the participant or given to her at the time of next contact (Appendix 8).

Voluntary Participation

Participation in the study was voluntary. Pregnant women were invited to participate but had the right to choose whether to participate or not and also to withdraw at any stage. These details were included in the participant information sheet and discussed with each woman.

Confidentiality and Anonymity

The issue of confidentiality and anonymity was discussed individually with each woman. Women were advised that all research standards regarding anonymity and confidentiality would be adhered to. The secure storage and use of personal data and interview audiotapes and transcripts was confirmed with each participant, according to research standards. Personal details of participants and their corresponding pseudonyms were only recorded in written files that were stored in a locked filing cabinet in the researcher's home office with the key held only by the researcher. Pro forma copies of the Research checklist and the Confidential Field work Notes are shown in Appendix 9. Transcripts and any excerpts of interviews were only identified by pseudonym, with any identifying details excluded from the data analysis. Electronic data were also only identified by pseudonym and were stored on a computer used only by the researcher and secured by password. Backups of electronic data were stored on external electronic storage devices.

The only situations where confidentiality would not be maintained were outlined to participants. These were if the woman herself gave consent to release her information; or if it was required legally, such as if the mother or baby were at risk, in which case the researcher would discuss this with the mother and assist her to obtain appropriate support.

Women were invited to choose their own pseudonym, or to adopt one from a page of names provided by the researcher. It was considered that this would assist women to feel that their identity was concealed, and also to give them a choice in the selection of their own pseudonym. In addition this gave the participants ownership of their role in the research. Women with partners were also encouraged to choose a pseudonym for their husband or partner if his name was mentioned in the interview. As the research was conducted in a rural area there was a slight possibility of the audio typist recognising a participant's voice, even with the use of a pseudonym. To address this dilemma the researcher advised participants of the name of the project typist, in order

that if a participant knew the typist a different typist could be employed to preserve their anonymity.

The Interview

Interview Technique

The research interview technique in phenomenological research can be likened to a dance between the researcher and the participant. In this study van Manen's approach (1997) was followed. This involved the researcher keeping close to the investigation of women's lived experience of early motherhood. Participants were encouraged to be concrete in describing experiences. A single question was used by the researcher to begin each of the three interviews. As participants shared their experience of being a mother the researcher offered small prompts and encouragements to explore what they were sharing in greater depth. These were usually employed at the inevitable pauses in the conversation. For example: 'Yes', 'Mmm', 'Can you tell me more about that?'. Pauses and silences were also used, giving the participant opportunity to reflect before responding. Other interview skills used included clarifying, reflecting, paraphrasing and the use of open questions, for example 'How did you feel?' Maternal and child health nursing skills, and careful study design helped to build rapport with women, which also facilitated the interview process. The interviews were essentially 'conversations' (Bergum 1986). They were like a dance that ebbed and flowed or swirled to the internal music underpinning the lived experience of the participant and the attentive listening of the researcher. Extracts from two interview transcripts are attached as Appendix 10.

Audio Taping of Interviews

It was decided to audiotape the interviews with participants so that all aspects of the interview would be available for the process of analysis. The strategy of single use of

tapes was adopted to avoid the risk of taping over a previous interview and potentially losing data, to enhance confidentiality, and to allow audiotapes to be accessed repeatedly to facilitate interpretation and analysis. Each audiotape was then labelled with the participant's pseudonym and reference number. The date of the interview and whether this was a first, second or third interview was also recorded on the cassette. These tapes were stored in a locked filing cabinet to which only the researcher had access.

After each interview the researcher listened to each tape. The tapes were then forwarded to an audio typist for transcription using a transcribing machine with head set and foot controls. As each participant completed another interview the tape of the latest interview was secured with her previous tapes via an elastic band and stored in the locked cabinet.

Equipment for Interviews

All interviews were all recorded on a mini audio tape recorder, 11cm x 8cm x 3cm in dimension, with an inbuilt microphone. Standard size audiocassette tapes were used. The researcher carried a backup tape recorder, replacement audiotape and AA batteries in case of malfunction. Other materials taken to the interviews were paper and pen for recording notes, directions for locating rural properties, and a mobile phone in case of car trouble or getting lost. Labelled A4 size envelope files were created for each participant, and included biographical details, relevant medical details, and transcripts from previous interviews. This file was then taken when the participant was being interviewed.

Location of Interview and Initial Contact

Women were interviewed at a location or venue of their choosing. Most interviews were conducted in the participant's own home, with two interviews being conducted at the home of a family member where the participant was staying.

All interviews were arranged for a time that suited both the researcher and the expectant or new mother. Establishing a comfortable rapport with participants was recognised as critical in terms of both the participant being respected and valued as well as obtaining a quality outcome in terms of the research. This was a task that required conscious action, as at the initial interview the participants were only known to the researcher in the context of a telephone enquiry about the study or brief encounter at an antenatal clinic or class. This was identified as an important aspect of the interview as the degree of comfortable rapport would set the tone for the initial and subsequent interviews, and potentially the data collection process.

This rapport was achieved at the initial antenatal interview by the researcher identifying herself and greeting the mother when she responded to the knock at her door. General social enquiries about health or wellbeing or comments on weather were used to initiate preliminary contact. Making and maintaining eye contact, listening to the woman's responses, and taking note of her demeanour were important communication skills utilised in establishing rapport. The objective of this approach was to try and attend to the woman and to be sensitive to and aware of the nuances of her body language and general emotional state. Another objective of this approach was to foster and facilitate a sense of comfortableness between the researcher and each individual participant.

Confirmation of details provided over the telephone was also made, and if any information was incomplete it was obtained or clarified at this stage. This information related to basic profile details such as age, medical details and obstetric history (Appendix 9).

Atmosphere

There was a noticeable difference between the initial antenatal interview and subsequent interviews in terms of the physical setting and atmosphere. The antenatal

interviews had a sense of being leisurely. A quiet atmosphere characterized these interviews with only the occasional interview disrupted by telephone calls for participants. Some families had finalised preparations for the baby's arrival and some were still preparing, but there was a sense of order and organisation in all instances.

In contrast the postnatal interviews were completely different as each new baby had a definite presence in the home. Some babies were awake and up during the interviews. Some were being fed, others lay on a mat on the floor and a number were being settled to sleep. Most of the postnatal interviews involved several interruptions while babies were settled to sleep, had their nappies changed, were fed or were held in their mothers' arms. On several occasions babies were unsettled or crying intermittently during the interviews. Mothers were encouraged to indicate if they wished to pause the conversation for a period to attend to their baby, and this was done on several occasions. For other interviews women chose to continue the interview conversation as they changed nappies, or rocked their babies in their arms or pram. Even when the baby was asleep in another room their presence pervaded the home via bouquets of flowers, baby congratulation cards, play mats and baby gyms, nappy bags, change tables or change mats, tiny baby clothes on a clothes horse or folded on a bench and breast pumps or feeding bottles on the sink.

Managing Issues in the Interviews

Quality of Sound

In some interviews it was difficult to place the tape recorder in a position to optimally record the conversations held with participants. In general an excellent quality of sound was obtained from the participant's voices, but the researcher's voice was recorded very quietly. This difficulty was overcome as skill in determining optimal locations for placing the tape recorded in the various settings developed. Most interviews were conducted at kitchen or dining room tables, which was easier in terms of gauging optimal recording distances. Up to one third of interviews took

place in a lounge room setting and accordingly required manoeuvring of furniture to appropriately locate the tape recorder. In each case the participant determined the interview location. On several occasions the interview began at the table but relocated to the lounge room as the baby woke or became hungry and needed feeding.

Background Noise

Background noise was a problem in only a small number of interviews. Most commonly the situation involved an unsettled baby who was crying intermittently during the recorded conversation. Sometimes music or a television program was audible in the background and in these instances the participant was asked if it could be turned down. Such requests were amicably received and addressed. On one occasion the participant's husband was unpacking the weekly groceries during the interview, which was held in the kitchen. There was intermittent noise with the rattling of plastic bags. This occurred after the interview had started, and as a guest in her home the researcher did not feel comfortable to ask the participant to relocate to another room. Fortunately the recorded conversation could still be transcribed satisfactorily. It would perhaps be appropriate to indicate when initially discussing the project that a quiet environment would be most suitable for recording interviews.

Where a baby was unsettled, fractious, or crying the researcher's experience as a midwife and maternal and child health nurse was used to convey a relaxed accepting attitude to attempt to assist the mother to relax and minimise stress on herself. Attempts were also made to acknowledge the babies in the conversation and give them space to present their voice. The participation of the babies was invited and affirming statements were used. (For example: What do you think? Would you like to tell us something about that? It must be uncomfortable when you have wind in your tummy … and so on). Many of the interviews were relatively quiet if the baby slept during the conversation with the participant. However the instances where the baby was unsettled, fractious or needing feeding or changing were striking in the contrast with the busyness and activity required for baby care. Here participants were

constantly dividing their attention between their conversation with the researcher and the needs of the child, and sometimes interacting with their partner by giving instructions or answering questions.

Tearfulness

A few of the participants became tearful as they shared their experiences of grief concerning the death of their mother or grandmother just prior or during their pregnancy. One participant cried as the interviewer attempted to explore the issues that led to her feeling overwhelmed as an expectant mother. Her family members were all interstate and she had only been living in Victoria for a few months

Although the researcher is very used to women feeling upset and crying in the work situation, the situation seemed more difficult in the voluntary research setting. On this occasion the tape recording was paused. The situation was managed by acknowledging the woman's feelings and how it must be difficult. When the woman indicated that she was happy to continue, the conversation was turned to a less sensitive topic to allow her to regain control. Later on the interviewer gently touched on the original topic for the participant to add anything she wanted prior to closing the interview. After the interview was completed the researcher stayed and chatted briefly to confirm that the participant was no longer upset.

Concluding the Interviews

Each interview lasted between 45 to 90 minutes and 39 interviews were conducted in total. The interviews mostly came to a natural conclusion. As the conversation seemed to be completed the researcher advised the participant that the interview would be finishing soon. At this stage the participant would be asked if they had anything else they would like to add or say prior to finishing. Sometimes participants did make additional comments or shared further insights about the experience of motherhood, and on other occasions they did not. Each interview was concluded by

thanking the participant for sharing their experiences. After the first interview arrangements for participants to contact the researcher after their baby was born were made, requesting that if possible this be done in the first 1-2 weeks after birth when the mother was able. After the second interview an appointment was made for the third and final interview.

Phenomenological Reflection

After each interview was transcribed the researcher listened to each audio tape and read each transcribed interview to confirm accuracy of the transcription. Transcribed interviews were set out as per Appendix 9 in a column on one third of the page to allow space for line by line notations and theme summary notes. Each speaker in the interview was identified and reference numbers were allocated to facilitate ease of location of particular thoughts or comments. In total 1255 pages of transcribed conversation and notations were compiled.

The research activities identified by van Manen were used as a framework to explore and reflect on the lived experiences shared by the participants. van Manen identifies six methodological themes as a guide to hermeneutical phenomenological human science research (1997). He argues that hermeneutic phenomenological research is a dynamic interplay of these research activities, which are:

1. Turning to a phenomenon which seriously interests us and commits us to the world.
2. Investigating experience as we live it rather than as we conceptualise it.
3. Reflecting on the essential themes that characterise the phenomenon.
4. Describing the phenomenon through the art of writing and rewriting.
5. Maintaining a strong and orientated pedagogical relation to the phenomenon.
6. Balancing the research context by considering the parts and the whole. (van Manen 1997:30-31).

Dwelling with the data involved the researcher in reading and re-reading each transcribed interview. The next phase involved recovering the strong core themes from the transcribed interviews. van Manen (1997) suggests three approaches to reveal and isolate the themes related to a phenomenon in a text. In this research study each of the techniques was employed. In the first 'holistic reading approach' attention was given to the text as a whole. The question reflected on concerned: what phrase captures the main significance of the entire text? The next strategy involved several readings of the text. The question considered here asked: what statements in the text seem especially revealing or essential about the experience being described? These statements were then highlighted. (van Manen 1997), The third approach involved a 'detailed reading' of sentences and sentence clusters and asking what they revealed about the experience being described. (van Manen 1997).

The transcripts were discussed with the research supervisors as part of the review of data collection and identification of themes. As the analysis progressed descriptions relating to particular ideas were collated together using a physical cut and paste process whereby photocopies of completed annotated interview transcripts were manually cut and ordered on to worksheets according to the particular themes identified. Care was taken to identify the information according to the relevant participant's pseudonym, interview number and transcript identifier. The original transcripts were put aside in a lever arch folder for ongoing reference and stored in a locked cabinet.

The information shared about each theme was reflectively explored. At times the researcher chose to hand write key sections of the transcribed interviews pertaining to particular themes to be fully immersed in participant's descriptions and experiences. This dwelling with the data enhanced reflection on the essential themes. The context of the research was balanced by being cognisant of the ideas in terms of the whole interview. This involved significant writing and rewriting as the reflection process continued.

Project Newsletter

Part of the research process involved periodic distribution of a project newsletter. The aim of the newsletter was to provide feedback to the people involved about the progress of the project. Participants were posted newsletters as a courtesy to keep them up to date and also a strategy to maintain engagement and interest with the project. The newsletter was also distributed to the local Council, the Directors of Nursing at the participating district hospitals, the midwives and the six medical centres who were supporting and promoting the research and local maternal and child health nurses. The project newsletters are included in (Appendix 11).

The initial newsletter briefly outlined the background to the study, the aim of the study and the research design. Information about the promotion of the project, and a progress report were included. Later newsletters detailed the progress of the study. Acknowledgement of the participants and supporters, and details about the distribution of the project findings and tips for new parents were detailed in each newsletter.

Thank you Cards

As the project progressed, maintaining participant engagement over a period of several months was a task that became of concern to the researcher. Some participants expressed interest in participating in the study early in their pregnancy and so were engaged with the project over a six month period. The circulation of the project newsletter partly addressed the need to maintain a connection with participants. It was considered that some further gesture was required, especially given the generosity of women in participating in the interviews. This took the form of simple cards that were posted out individually to thank women for their participation after each interview. The cards had a butterfly or motherhood image on

the outside and were blank inside. After completion of the final interview each participant was sent a letter on the project letter-head with a final card thanking them for their generosity in sharing their experiences and acknowledging their contribution to the project.

Additional Supports for Participants

Several additional supports were incorporated into the study design to enhance ethical support for participants. These comprised a resources list, access to the researcher between interviews and linkage to a primary maternal and child health nurse.

All participants in the study were provided with a contact list of independent *Resources for Mums.* This A5 sized 4 page directory comprised a detailed list of local and regional services available to mothers. It included independent counselling and social work services, early parenting centres, day stay programs, breastfeeding clinics, 24 hour numbers for maternal and child health help lines and maternity services. This was introduced at the initial antenatal interview and was designed to provide participants with easy access to independent resources if they wished. A copy is attached as Appendix 12.

Another support set up for participants was the ability to contact the researcher by telephone following interviews, if desired. This was instigated to provide participants with the opportunity to express concern or follow up any thoughts or issues that may have arisen during an interview. For example they may have wished to discuss something further or access support regarding an issue. This strategy sought to indicate to participants that they were valued as individuals and that the research project offered ongoing support, between interviews, if they wished to use it. However, none of the participants chose to contact the researcher between interviews.

Postnatally all participants were linked to a primary maternal and child health nurse (not the researcher) to ensure each participant had an independent maternal and child

health nurse providing nursing support. It is a routine practice in Victoria for each mother of a newborn baby to be allocated a nurse from the universal MCH service. In the case of this study at the first postnatal interview the researcher confirmed that each participant had been contacted by their MCH nurse and knew how to access them if required. The researcher avoided the situation of including her own or potential clients as study participants to avoid any potential conflict of interest and to ensure that participants were linked to an independent maternal and child health nurse.

Rigour

Rigour, in the context of research, is defined by Taylor, Kermode and Roberts (2006) as 'the strictness in judgement and conduct that must be used to ensure that successive steps in a project have been set out clearly and undertaken with scrupulous attention to detail, so that the results/findings/insights can be 'trusted'' (2006:400). The transparency of a project facilitates it being evaluated by others regarding the accuracy of the methodology and reflecting the truth or worthiness of the matter. Qualitative and quantitative research are based on different epistemological assumptions and consequently use different words to make the overall processes and worthiness of the project explicit. In qualitative research rigour is demonstrated by the researcher showing how they have obtained the evidence in their study and how that evidence has been confirmed (Streubert & Carpenter 2011).

Taylor et al. (2006) discuss in their work the criteria for assessing rigour in qualitative research as being credibility, fittingness, auditability and confirmability. The framework of these authors is drawn on to clarify these terms here (Taylor et al. 2006). Credibility refers to the extent that people reading the research recognise the lived experiences described in the research as being like their own experiences. Credibility is attained if the phenomenon can be recognised in the transcript or research report. The next criterion, fittingness, means the degree to which the findings of a project 'fit' into contexts outside the study situation. Fittingness also

includes the extent to which those reading the research view it as having relevance and meaning to their own experiences. The third criterion, auditability, concerns the provision of decision making steps so that another researcher can follow the thinking, decisions and methods used in the research. The final criterion, confirmability, is met in a project when the above criteria of credibility, fittingness and accountability can be demonstrated. This is confirmed by participants who assess the project's neutrality from the biases acknowledged by the researcher.

In terms of this research project rigour has been addressed at multiple levels. Firstly, credibility has been addressed by having congruence between the theoretical framework of phenomenology, the research question and the particular data gathering methods (Welch & Jirojwong 2011). In addition credibility has also been considered by careful attention to detail with data collection via interview techniques and collection of journal records. The fittingness of the project has been achieved in that research findings have been applied to settings outside the study setting. For instance, the findings regarding women's experiences of learning to breastfeed being used to support the case for establishing a local breastfeeding support centre. Another example is the finding concerning women's distress in the early days at home enriching awareness of outreach nurses about the emotional state and vulnerability of new mothers. Auditability has been addressed in this study by the transparent nature of the research. This has included careful record keeping; secure storage of audiotapes and transcripts; and regular meetings with the supervisory team. For instance, consultations with the research supervisors about data analysis included reviewing interview transcripts and themes as well as the organisation, description and interpretation of findings. Confirmability was achieved in the research by clarifying experiences with each participant during their interview and in a follow up interview where appropriate. In addition six transcripts were returned to participants as part of a 'member checking' procedure (Taylor et al. 2006). These participants confirmed the transcripts of their own interviews were complete and accurate. Participants were also invited to clarify anything they wished to and one participant requested that a comment she made be excluded from the data as she felt she had

exaggerated at the time, and this was attended to. Confirmability of the findings has also been obtained from peer feedback following discussions after the presentation of findings at national and international conferences of maternal, child and family health nurses.

Conclusion

This chapter, Investigating Lived Experience, has detailed the research method used in this study. Features of the research design have been outlined and discussed including the aim of the research, and the use of in-depth interviews and journal records to collect data. Ethical considerations were addressed. Management of interview issues and additional supports for participants have also been detailed. Finally, the process of phenomenological reflection and analysis and the issue of research rigor were addressed. Chapter 5 follows next and will explore the finding from the antenatal interview.

Chapter 5

Pregnancy:
The Transformation from woman to mother

Women are amazing.
Women can breathe and blink and walk and work
at the same time they are growing a baby.

Bernadette (9.1 B74)

Introduction

While the previous chapter detailed the study method, this chapter reports on the insights obtained from the initial antenatal interview, held when women were between 34 weeks gestation and term in their pregnancy. The question informing the interviews asked participants about their experience of being a mother at that time. Key themes underpinning women's experience of early motherhood during pregnancy included life changes, living the physical and emotional experience of pregnancy, relationships, waiting and wondering. These insights will be detailed and supported by interview data and then encapsulated in a synthesis. An overview of the characteristics of the participants will be discussed first.

The study cohort comprised thirteen women who were first time mothers. The participants were aged between 18 and 34 years, with an average age of 28 years. Ten women were married, one woman described herself as engaged to be married and living with her fiancé, and another woman said she was in a defacto relationship and living with her partner. One woman described herself as single, and not in a relationship with the father of her child. The partners of the participants were all male, aged 21-36 years of age, with an average age of 30.5 years. Participants were from a rural municipality and consistent with this community were all of Anglo Saxon heritage and similar socio-economic background. Demographic details are shown in Appendix 13.

The participants were employed in a range of occupations prior to leaving work or taking maternity leave. Some women gave more than one occupation. Four women worked in office administration and two worked as pharmacy assistants. Other

occupations held by participants were: sales consultant, cook/kitchen hand, mechanic, massage therapist, book keeper, librarian, paramedic, journalism student, and home duties. The husbands and partners of women in the study also had diverse occupations. They or their partners described their occupations as labourer, labourer/musician, vineyard worker, real estate agent, mechanic, armed forces personnel, carpenter, truck driver, television producer, accountant, self-employed with quarry business and fitter.

All participants either lived or attended antenatal care in the local Shire. Eight of the thirteen participants lived in rural areas outside of any township. Four participants lived in small rural townships (population less that 2,000 people), and one participant lived in a medium-size rural township (population less than 5,000 people). At the time of the first interview eleven participants lived in houses or units with their husband or partner. One woman and her husband lived in a converted shed on a rural property run by members of their extended family. One participant was single, and she had moved back to her parents' home during her pregnancy.

During the course of the study two women changed their living arrangements. One participant separated from her defacto partner following discharge from hospital after giving birth, and moved back home to live with her parents. She was concerned about her partner's use of recreational drugs and did not want their child exposed to any risk taking behaviour. The other participant who altered her living arrangements during the study period was a single woman who moved back into a flat of her own when her child was about nine weeks of age. She had lived with her parents after changing work places during her pregnancy. After recovering from a Caesarean birth she obtained a flat of her own to rent for herself and her baby.

Life Changes

All the participants in this study experienced the transition from woman to pregnant mother as a significant transition in their life. Ten of the thirteen women were pregnant for the first time. Two women had experienced previous terminations of pregnancy and another had a pregnancy miscarry the previous year. Eleven of the women had planned pregnancies. Most of the women with a planned pregnancy reported conceiving within a

few months of trying to become pregnant. Several women anticipated that it might take some time to become pregnant, and some were quite surprised by how quickly they had conceived. One woman had been trying to become pregnant for over a year and conceived while away on holiday. Seven women mentioned their age as a factor in influencing their decision to have a child at this time and these were generally aged 30 years or more.

From Woman to Pregnant Mother

A small number of women in this cohort had unplanned and unexpected pregnancies. Jess was an 18 year old student who had been hopeful of undertaking tertiary study and a career in Melbourne. Sarah, 23 years old, was employed full time and became pregnant after a brief relationship with a work colleague. For these women, having a baby and becoming mothers resulted in major life changes. Career plans were upturned as their lives took an unexpected course and they took on motherhood. Jess finished school and moved in with her boyfriend. Sarah changed jobs when she was about 8 weeks pregnant as she did not want to cause difficulty in the relationships with her work colleagues. In addition, Sarah kept her pregnancy secret from her parents until she was 24 weeks gestation.

The women who had planned pregnancies also reported that having a baby was a significant turning point in their lives. All women were in paid employment when they became pregnant and most continued paid employment throughout most of their pregnancy. One couple had moved from interstate during the woman's pregnancy. Most women planned to take some maternity leave from their work in at least the initial months after giving birth. All had left work at the time of the first interview, with many on maternity leave of some kind.

Participants grappled with a number of issues in the transition from woman to pregnant mother. Most were pleased to finish work due to excessive tiredness and fatigue. For some participants being home during the day was a challenge after being used to working outside the home and having busy schedules. Sarah, for instance, worked up until 35 weeks gestation and found it very difficult just being at home. She commented:

'I just want something to do (laughs). I'm just bored with sitting around... The days drag a lot...' (4.1 S81).

For a number of others the transition from a dual income to a single wage was challenging, but manageable. Hayley, 25, noted that: '*Over the last few weeks at work it was like 'my God we're going to be on one wage soon' (laughs). That was a bit scary... [but] we'll cope' (13.1 H105-H106)*. For some the transition from being an employee with an income to being a homemaker without an income was difficult, especially the women who were in defacto relationships. For instance, Lee-ann, 30, commented that.

> *... I find it's pretty stressful. Because it's the first time in my life that I actually have to be reliant on someone else. For wages, for income, for that sort of support. I've always been able to pay my own way because I've always had a job… And having to ask someone for $5 or $10 is a very big thing for me (11.1. L1-2).*

Seeing life differently

A number of participants commented that they were seeing life differently since they had become pregnant. For instance, news of international disasters weighed heavily on participants during their pregnancies; they felt more sensitive to tragedy and humanitarian crises. Some commented that they began to wonder if they had done the right thing bringing a new baby into the world, with the sadness it contained. Xerri said: *'I think we did not really worry about things before' (1.1 X4).* She explained that she and her husband would sit and wonder at the events of the world: *'The world's gone crazy, are we doing the right thing bringing a baby into the world when it's like this?' (1.1 X4).* Xerri felt pregnancy *'makes you think about things a lot more' (1.1 X4).*

For other participants, such as Sarah, seeing things in a different light concerned a shift towards being more responsible and organising a home for herself and her baby. Sarah shared: *'...I miss being able to drop everything and do what I want to do. I'm sort of starting to be responsible (laughs) which is weird.' (4.1 S72).*

Other situations were described where participants reported seeing things differently. Xerri for one noted that her attitude to parents and young children had changed. She admitted that prior to her pregnancy if she saw a mother with a disruptive child she would be thinking that mother should be controlling her child. Now, as an expectant mother she would look at the same situation and feel empathy for the mother, and reflect on what a difficult day the mother must have had. She muses that her pregnancy

> *'has made me realise what other people are going through a bit more... it's changed the way I think of mothers and children' (1.1 X58).*

Becoming a Family

For the majority of women who planned their pregnancy, becoming pregnant was part of a defined plan to add children to their relationship and begin a family. In other words, as several participants commented, they recognised that a baby was here for life. Consequently it was important, as Lee-ann emphasised, to be careful to think things through in advance.

> *A baby is not just a two-minute thing .You've got to look at making sure you've got firewood there for next winter. You've got to make sure your baby's going to be comfortable then. You've got to make sure that the family's happy and healthy… [and] you are going to be self-sufficient having a vehicle and those sort of things… (11.1 L97).*

Some participants had been contemplating having a baby for up to five years. Rose shared that she had *'always sort of known [she] wanted to be a mum' (5.1 R45)*, but admitted that *'James and I sort of procrastinated for ages (laughs) before we decided to have kids' (5.1 R8).* They would go through stages of contemplating a baby and then deciding to work and save for a while longer and had now finally decided to start their family (5.1 R5, 8, 11, 16-17).

The theme of planning to have a baby was supplemented by the concept of being ready for the change starting a family involved. While many participants focussed on being

ready financially, others spoke about being ready for the broader change in life that beginning a family would require. Gail observed: *'it's going to be a different change of a lifestyle, which I think we're both ready for. And I cannot wait… [to] raise a little baby and seeing them grow up and do all the things that they do (7.1 G79)'*. Several other participants also articulated that they anticipated having a child would change their life and as Ursula said: *'... but in a really good way. Yeah, I think I'll have a real purpose to life'* (8.1 U51). Xerri commented that she felt beginning her family was a worthwhile thing to do (1.1 X25).

Part of becoming a family involved being responsible for others. The idea of being responsible for someone else pervaded all the interviews. Participants shared that they were cognisant that they were going to be responsible for the child and person their as yet unborn baby would become. This knowledge was a little daunting at times for some, but also exciting. Women commented that it would no longer just be themselves, or themselves and their partner. They were becoming a family and would have someone else to think about and factor into their decisions.

Angela explained that she and her husband had established their home, were financially settled and over a period of time had felt they were ready for the commitment of having a child and beginning their family. They recognised it was a significant commitment that would affect their lives forever.

> *… All our friends have had babies and... Well I'm thirty-one, my husband's thirty six so it's sort of an age factor too I suppose… but over a period of time you think 'Yeah I think we are ready for that'. Because it is a big commitment. It's a life changing commitment. I mean it's forever (laughs). ' (2.1 A50).*

Synthesis: Life Changes

The existential tenets of lived time, lived other and lived body are all evident in the study insights concerning 'Life Changes' and the transformation of woman to mother. The lived experience of pregnancy involves hopes and dreams of parenthood, creating new life, forming a family, unifying and completing a relationship amid daunting apprehension at being responsible for one who is completely dependent. Pregnancy results a raft of changes in a woman's life as she is transformed into a pregnant mother.

Significant events such as moving house, changing jobs, taking maternity leave, adjusting to a single family income and being reliant on someone else for financial support take on additional importance Pregnancy invites reflection on what has transpired, 'seeing life differently', having increasing interest in and empathy for other mothers and being more sensitive to reports of tragedy and crisis.

Transition to motherhood was also influenced by the physical and emotional experience of pregnancy, which will be discussed next.

Living the Physical and Emotional Experience of Pregnancy

Pregnancy was viewed by the participants as a very physical and emotional experience. Women shared rich descriptions of their physical and emotional experience of pregnancy. Key topics addressed by women included morning sickness, breast changes, 'having a pregnancy tummy', feeling flutters and jabs, fluctuating emotions and feeling uncomfortable towards the end.

Morning sickness

Morning sickness was experienced in varying intensities from none to severe. Most participants experienced a mild degree of nausea and vomiting, and described feeling nauseous when they were hungry with the feeling settling if they had something to eat. A few commented that they did not have any morning sickness. For others it was a more significant, where smells from activities such as washing hair, cleaning teeth or opening the dish washer resulted in retching and vomiting.

Nausea and vomiting would often worsen with movement so resting in bed or on the couch was the only way some women could manage it. Dianne had severe morning sickness and was very ill for the first 14 weeks. She could only retain one meal a day, which her husband cooked in the evening. Dianne's parents attended to her household tasks and other chores such as shopping and banking. After 14 weeks gestation, Dianne stated her morning sickness was much reduced but reported she still vomited several times a week for the remainder of her pregnancy (12.1 D23-31). Christie similarly

experienced a lot of nausea and vomiting, but was able to continue working. She shared: *'I would leave here [for work] and have to pull over on the way to be sick in the bushes, and then get to the front gate of where I'm going and be sick, and then walk in like normal' (6.1 C22)*.

Breast changes

Breast changes were the first sign of pregnancy for almost all the women participating in the study. Several women stated they knew they were pregnant prior to having a positive pregnancy test because of the changes observed in their breasts. Hayley noted that her nipples were more erect and her breasts were much more sensitive. In addition, Hayley's breasts increased in size immediately, and she required new work shirts. Most participants, in fact, reported an increase in breast size. Some were very pleased to have larger breasts. Others had hoped for bigger breasts and stated they were feeling a bit disappointed when this did not occur to the level they wanted. Angela experienced a big increase in the sensitivity of her breasts, and reported that *'I remember that they were really sore, I mean even to have a sheet on them at night time I was like 'oh!' (2.1 A6).*

'Having a Pregnancy Tummy'

The growth of the unborn baby naturally caused the women's abdomens to increase in size dramatically. At the time of the initial interview women were pleased as this reflected their pregnant state visually and declared their pregnancy publicly. Some women noted that it was hard to comprehend that they were really pregnant in the early weeks prior to 'showing'. Others commented that they felt the pregnancy became more real for their partners once this body change was evident.

Most women spoke affectionately about their 'bump' or 'baby belly'. Some said they began to show from about 14 weeks. Christie was pleased to have her pregnancy finally show and was quite proud of her tummy at 33 weeks gestation:

I'm just so glad I've got this tummy, coz I've always just wanted a big pregnancy tummy (laughter). I used to wear tops like the maternity top, to kind of show it was a bit of a tummy starting, but there was not really much there (laughter) (6.1 C19).

Xerri shared that she was very attached to her swollen abdomen and would miss it terribly after her baby was born. *'I do love it; I'm so in love with my stomach... I mean sometimes it feels like I've swallowed a watermelon and it gets in the way, but other than that, no I love it. I love being pregnant' (1.1 33X)*. Angela commented that she felt big, but was not as big as she expected to become: *'...it feels good... I thought I'd be really like a big elephant, (laughter) but I feel like I'm just pretty much all baby and... I will not take long to get back to how I was' (2.1 A15)*. Dianne similarly disclosed her self image: *'I feel like a little elephant but at least I'm not swollen all through my legs or anything... I've been pretty lucky that way things have stayed pretty normal' (12.1 D38)*.

Many of the participants said that their 'tummies' were quite tight and basketball like when interviewed later in pregnancy. Some women experienced difficulties in terms of spatial awareness and reported bumping into things especially benches, so they had to now allow extra space between them and such objects. Other women reported difficulty bending over due to their baby impeding their ability to bend in the middle. Hayley spoke about what having an enlarged tummy was like for her. She admitted *'I walk into things all the time (laughs). I'm not very balanced' (13.1 H76)*. She discussed the extra effort involved to move about, saying: *'...it's awkward trying to pick things up off the floor. Like doing washing and everyday things... nothing's really that hard but it is an extra effort for everything that you do' (13.1 H77)*.

Not being able to complete heavy tasks that they would usually manage was difficult for some participants. Lee-ann described herself as a *'very independent person'* and commented that she could not get around as easily as she could before, *'I cannot get and chop all the wood and get all the feed for the horses and things like that. I'm used to being able to do for myself' (11.1 L3)*. She explained that due to her size she could no longer do tasks she would usually do for herself.

Feeling 'Flutters and Jabs': Baby Movements

The presence of the baby within their bodies was a physically powerful experience for the women interviewed. Participants reported recognition of the baby's first movements occurring between 14 and 23 weeks. Many of the women described the sensation as a 'fluttering' feeling, or a series of 'flutters'. Often women compared the feeling to brief moments of abdominal wind. Hayley described her baby's first movements as: *'almost like wind but different from wind' (13.1 H58)*. She went on to explain that she knew that it was not that, but that was probably the easiest way to describe it. Hayley shared that *'It took me a little while to sort of realise what it actually was' (laughs) (13.1 H58)*. Rose noted that her baby's movements sometimes make her feel unsettled in her stomach. She commented that: *'...sometimes it makes me feel sea sick because it feels like it's swishing through all that fluid and it makes me feel a bit sick' (5.1 R 61)*.

Some of the women offered alternative descriptions of their baby's first discernible movements. Bernadette said she did not feel a fluttering or anything, *'It just felt like two snakes just twisting around. Or…two muscles or something just having (sic) a twist in the beginning' (9.1 B75)*. Bernadette and her husband were actually at a concert when she was first aware of her baby's moving, which made the moment particularly special for her. In contrast, Kate described her baby's movements as fascinating. She said that it was hard to really convey what the baby's movements felt like and likened it to an incident in a movie: *'There's a scene in Space Bowl where this bloke in a bar has an alien jump out of his stomach (laughs) and I always think of that. Alien baby in my stomach' (10.1 K23)*.

There was consensus among the participants that the baby's movements increased in strength as the babies grew. Kicks became stronger, sharper and more noticeable as the space available reached its limit. Gail described her baby's movements as *'like a flutter'* but cautioned that *'every now and then you sort of get a boot and you think 'oh, that hurt' (laughs)' (7.1 G31)*. She explained that she usually felt the hard kicks *'mainly in the sides or down low' (7.1 G32)*. Gail shared that she experienced a lot of pain low from movements from seven months of pregnancy onwards.

Play Time

Most participants reported feeling pleasure at feeling their babies move. Almost half of the women interviewed spontaneously described playful interaction with their not-yet-born babies. Rose shared she enjoyed trying to determine the different body parts of her baby as it kicked, *'...I just laugh ... I'm trying to feel what is where ...bum or elbow or knee, whatever is happening'* (5.1 R61). Gail delighted in her baby's active periods:

> *It's a weird feeling... hard to explain coz it's like something is alive inside you but it's just like something's in between your skin and it's going around...I love the feeling. I sit there and I think 'oh come on, move, move, move'. Just seeing it move, now that I can actually see lumps every now and then… (7.1 G29).*

In a similar vein, the interview with Ursula opened with her speaking about her enjoyment of the sensation of her baby moving around. She described how she loved to try and grab her baby's little feet. Ursula described herself as a bit of a tormentor because if her baby was not moving she would poke or prod the baby just to make sure he or she was okay (8.1 U71). She had also observed that her baby '*seems to like [her] husband's voice [as] it always really responds when it hears his nice deep voice*' (8.1 U73).

In another illustration of maternal play Bernadette described the wriggles and jiggles observed in her tummy during a bath. She commented that her baby 'was going crazy' and added: '*...to see the bath water sort of wave around is incredible. I just put the book down and just watch the show… it's so intense when bubby moves. It's amazing*' (9.1 B78). Another participant described playing a game with her baby where she tickled the top of her belly to get her baby to respond with a kick (11.1L34)

These excerpts provide rich descriptions of women experiencing the movements of their unborn babies. They also illustrate how women relate to their babies as individuals by enjoying their presence and engaging in play.

Feeling Emotional

Almost all participants reported experiencing fluctuations in their emotions during their pregnancy. This ranged from a slight tendency to tearfulness to a very marked roller coaster ride of intense emotions. The women who described only slight tearfulness shared that they would cry in response to sad programs, films and even advertisements on television, things that previously had not affected them. Sometimes they would cry in response to sweet moments too, for example Kate shared that she cried as she watched an endearing scene on *The Simpsons* between the animated characters of Homer and Lisa *(10.1 K104)*. Another participant, Ursula, admitted crying when she saw community members involved in planting trees together around a local creek because she thought it was lovely everyone was involved *(8.1 U58)*. Other participants revealed that their emotions were more heightened since they had been pregnant. Women reported that their eyes would well with tears or they would cry about sad situations or circumstances or particular songs that had special meaning for them. One woman shared that during her pregnancy she always felt teary when listening to a particular song of John Williamson as it reminded her of her grandfather. The amplification of emotions equally applied to joyful emotions. Lee-ann recounted an episode with her family where she exploded into fits of hilarious giggling and laughter to the extent that tears rolled down her cheeks for about 20 minutes.

For some women the variable and intense emotions only occurred in the first three months, while for others it continued throughout their pregnancy. Several women divulged that they were more grumpy, cranky or irritable since becoming pregnant. Kate described herself as being grumpy in the morning, which was not a new feeling but was one which was much more intense with the pregnancy. Other women shared that they felt frustrated and annoyed if they were fussed over.

Women spoke very honestly about their emotions. For example, Jess reported that before she was pregnant she hardly ever cried but that she had cried more during her pregnancy than at any other time in her life *(3.1 J93)*. She said she was *'so moody and emotional some days it was shocking' (3.1 J92)*. Early in her pregnancy Jess was completing school exams, and she shared that she cried every single night for two

months *(3.1 J91)*. In her late pregnancy interview Jess commented that she could swing from happy and laughing to crying over nothing in less than half an hour. Situations that might trigger Jess crying included her partner coming home late or not spending enough time with her. Jess added that on other days she did not care what time her partner came home *(3.1 J90)*.

Feeling Uncomfortable Towards the End of Pregnancy

Another theme in the women's discussions of their lived experience of early motherhood was the discomfort of a term pregnancy. Being bigger in size, carrying the weight of the pregnancy and having the baby resting against body organs cumulatively contributed to this physical discomfort. Back ache, heart burn and swollen hands and feet were common experiences for a number of participants. For instance, Rose reported she was experiencing pelvic pain and it was uncomfortable for her to walk. She commented that sometimes she would think *'Oh, I cannot wait for that to end' (5.1 R56)*. Gail also described her experience of the discomfort of a term pregnancy resulting in her leaving work early at 32 weeks gestation.

> *...I had to finish work because I was getting really sore and a lot of pains right down low and in my back... there's a lot of walking at work and I'd get to the end of the day and I'd get home and 'oh, I cannot move I'm just too sore' (7.1 G17).*

For others, the position or activity of the baby likewise caused discomfort near term. A number of women commented that they felt the baby was running out of room. Kate reported *'more jabs and whacks'* as her pregnancy approached term *(10.1 K21)* while Hayley reported that her baby's movements were sometimes painful. Late in her pregnancy Hayley was feeling numerous movements under her ribs which felt like pressure. As she drew closer to term her baby had moved further down into her pelvis and the movements were felt in her side. Hayley related that her stomach often moved dramatically to one side with the baby's activity and it was *'like [her] muscles want[ed] to tear' (13.1 H69)*. Similarly, Rose was getting jabs in the ribs from the baby's movements and found it hard to get comfortable enough to sleep *(5.1 R55)*.

Settling to sleep was difficult and uncomfortable for many participants and often sleep was disrupted by the discomforts of a term pregnancy. Gail, for instance, noted that her baby mostly moved at night as she was settling to sleep. She reported that: *'...I'll lie down and relax and… the minute I lay down I think 'oh I have not felt it move for a couple of hours'. Yeah, then for hours (laughs), hours and hours it just moves' (7.1 G37)*. Many women described feeling awkward and heavy as their pregnancies neared term. Angela, for example, details how the heaviness and awkwardness of her pregnant body impacted on her as she tried to sleep:

> *... some nights ... you're so uncomfortable in bed you think 'God, I'm never going to get to sleep' because you cannot just roll over like normal. You've got to roll in three stages, and you groan and you grunt and then you get in a comfortable position, and hello you have to pee again (laughing). Then you get back up to the toilet… (2.1 A68).*

Synthesis: Living the Physical and Emotional Experience of Pregnancy

The existential tenets of lived body and lived other (van Manen 1997) frame women's insights of living the physical and emotional experience of pregnancy. Significant features of the lived physical experience of pregnancy included varying intensities of morning sickness and breast changes. A swelling rounded abdomen declares the pregnancy publicly and makes the pregnancy more real to women and their partners. Early foetal movements also contribute to the physical reality of the pregnancy. Feeling the baby move was generally pleasurable to for women. Women offered descriptions of spontaneous playful interaction with their yet-to-be-born baby.

Another aspect of the physical lived experience was that as the pregnancy advances and women's bodies increase in size and alter shape women sometimes bump into objects or find it awkward to bend down low. Being physically bigger in size, carrying the weight of the pregnancy and having the baby press against body organs contributed to the physical discomfort of the pregnancy as it approached term. A myriad of discomforts emerged: back or pelvic pain, heart burn, swollen hands and feet, pressure from the baby's kicking, difficulty rolling over in bed.

Women's lived emotional experiences included fluctuating and heightened emotions ranging from slight tearfulness to a roller coaster of intense emotions. Hilarious giggling and laughter, increased irritability and grumpiness characterised some women's experiences while others felt frustrated or annoyed if they were fussed over. These insights have presented women's experiences of the physical and emotional experience of pregnancy. A further important area of lived experience is that relating to women's experiences of relationships during pregnancy.

Relationship Changes

Women's experiences of relationships during pregnancy

The insights revealed about women's experiences of their relationships during pregnancy focussed on relationships with their partner, their unborn baby, their mother, and others.

Women's Relationships with their Partner

Women's accounts of their relationship with their partner during their pregnancy generally unveiled themes of understanding and support, communication, and closeness. For a small number of participants who were single at the time of conception the news of pregnancy created at least initial tension and awkwardness.

Women with planned pregnancies described the support from their partners as ranging from good to very strong support. A number of these women commented that their partners took on additional household tasks to ease their load such as vacuuming and carrying firewood. One participant described how her partner cooked dinner every night and attended to their business accounts to help and support her when she was affected by severe morning sickness. On the other hand, some participants reported their partners being over protective and cautioning against lifting heavy objects. Kate, described her partner being much more understanding and tolerant when she whinged. She laughingly explained *'I think he's more understanding of me at the moment ... (laughs). Usually if I whinge it's like 'oh shut up' (laughs)' (10.1 K131).* On a humorous note participants

described needing physical assistance to be levered off couches. Then there was Kate's partner Jack who walked behind her up hills at 35weeks gestation, in case she fell. Kate said he reasoned that if she fell over she would start rolling down the hill and be difficult to catch.

Communication with their partner was a central factor in most participants' experiences of their relationship with their partner during pregnancy. Most women described spending a lot of time discussing their pregnancy with their partners. Despite this, participants reported shared communication about feelings and perspectives occurred to varying degrees. Gail particularly valued the importance of communication in her relationship with her partner and commented:

> *... I just think it's the key to having a family. ...So the more you can talk I think the better and easier it's going to be for both of us. .... I suppose you have to talk. If you can't talk then it's only going to lead to problems between us. So we know that if we can talk now like, we have a great relationship (7.1 G48-49).*

A number of participants reflected that their pregnancy had brought no real changes in their relationship with their partner. Conversely, as the conversations continued in the interviews women would identify aspects of their relationships with their partner that had changed. This is illustrated by Xerri who commented that her pregnancy had settled them both down and made them more *'homey'*. They were, for instance, more content to be home on a Saturday night and fall asleep on the couch *(1.1 X38).* Other participants reported that their pregnancy had brought them closer to their partner, even though they believed they were already very close. For instance, Xerri described having a baby making her and her husband *'more united, just knowing we've done this, we've made this baby' (1.1 X51).* She felt the pregnancy had *'completed'* their relationship (1.1 X51-52).

Lee-ann similarly commented that there were no differences in her relationship with her partner since her pregnancy. Later on, however, she reflected that *'physically we're not as attentive to each other and we're not kissing and cuddling as much as we used to' (11.1 L91.)* She explained that in the first six months of her pregnancy they had been very intimate, but this had waned the past few months. Lee-ann shared her perspective

on this: *'But I think that's got more to do with the fact that he thinks I'm a china doll. Doesn't want to break me. You know, because the bump is in the road all the time' (11.1 L91).* Most participants chose not to spontaneously discuss their sexual relationships during their pregnancy.

The two participants who were single when they became pregnant described more challenges in their relationships with the father of their baby. Jess, who was still at secondary school, was frightened about telling her boyfriend about her pregnancy, particularly because they had planned to travel. She related: *'I was terrified because I didn't know how to explain it ... that was the biggest obstacle' (3.1 J33).* Jess later moved into a place with 'Fred' and shared that he had been helpful and supportive at times and was distressed when she was accidentally hit in the abdomen by a basketball. On the other hand Jess believed that her boyfriend, now her defacto partner, had not really thought much about becoming a parent and that she found it very difficult to engage him in conversations about matters that were important to her. She disclosed that she felt he was taking

> *'it a bit all for granted at the minute. [When] I try to have a serious conversation with him he gets drunk and storms off and comes back later on [saying] 'you don't listen to me, you don't know what I'm trying to say' (3.1 J67).*

Sarah's pregnancy had a big impact on her relationship with the father of her baby. As they were work colleagues she decided to change jobs to avoid issues in the work place. As she did not having an ongoing relationship she did not advise him of her pregnancy until she was almost half way through it As Sarah approached term she was still waiting to hear if the father of her baby wanted to be involved in any way in her baby's life, and if he did, to what extent.

Women's Relationship with their Baby

Participants explicated their relationship with their baby in terms of the themes of the presence of their baby, their sense of the baby and interaction with their baby. The presence of their baby was described as being real for most participants after seeing the

foetal heart beat on the first ultrasound. Foetal movements also affirmed the presence of the baby to participants and Dianne shared that she liked to hear the heart beat and know her baby was okay and *'it was good to feel it moving around' (12.1 D14).*

Participants' sense of their baby was described disparately. Some of the women described having *'no thought or expectation of what the baby might be like' (4.1 S93)*, and felt this was good as they would not be let down, Others anticipated it would be wonderful and lovely to have a little baby but confessed *'it is hard to think about the baby because it [was] hard to relate to it being [from] here in my stomach to actually holding it' (2.1 A53)* In contrast, some participants felt they already knew their baby and looked forward to meeting him or her. Several participants anticipated hopes for their baby such as being healthy and happy, wanting to *'nurture'* and *'be there'* for their baby and letting him or her develop into its own person *(1.1 X77).*

The initial conscious awareness of the baby moving inside them had a significant effect on the women interviewed. Kate described it as *'Amazing. That first kind of real confirmation that there's actually another living thing inside you' (10.1 K24).* The first discernible movements made most women think seriously about themselves becoming a mother. Kate's thoughts represent those of most participants. Kate commented that the baby's movements confirmed that the pregnancy was very real. She reflected: *'I'm responsible for this little life. [It is] completely dependent on me and it's a little scary' (10.1 K28).* She added that it made her think about how scared she was that she 'might muck up.' Kate recognised that she was responsible for the life of her child and her baby was totally dependent on her *(10.1 K25-28).*

Interaction between women and their not-yet-born babies has been described regarding 'Play'. In addition several participants also described interacting with their babies to sooth them from an active period into sleep. Dianne reports that when her baby is active he or she settles down if her belly is rubbed and returns to sleep (12.1 D19). Similarly, Lee-ann calms her baby from an active period by stroking her belly and talking to him/her and saying it is *'time for sleep' (11.1 L32).*

> *I mean you can be in the middle of the deepest sleep in the middle of the night and awake comes the baby and starts kicking the living daylights out of you. You're like*

'you're supposed to be sleeping now. This is time for sleep' and you talk to the baby and I find that helps soothe the baby and it normally goes to sleep (11.1 L32).

Several participants shared that they talk to their baby in utero. Kate explained that she talks to her stomach as she walks down the street and asks her baby what it is doing when it gives her a kick. She affirmed that she has a relationship with her baby and that she talks to him or her all the time. (10.1 K159).

These excerpts provide rich descriptions of women's experiences of their emerging relationships with their babies. They also illustrate women's experiences of relating to their babies as individuals by enjoying their presence.

Women's Relationship with their Own Mother

Participants described experiencing their relationship with their own mother during pregnancy in different ways. Themes that emerged here generally involved various kinds of support, but also comprised negotiating changed dynamics. All participants reported that their own mothers were excited about their pregnancies and they had received gifts from them for their babies. The majority of participants also described experiencing a supportive relationship with their own mother during pregnancy, although this was expressed differently for individual participants. Emotional support was a key area and most women looked to their mothers for this and appreciated receiving it. For example, Jess shared *'I wouldn't be able to do it without having Mum around' (3.1 J64).* Practical support, such as help with housework or shopping, were other ways participants described being supported by their mothers (1.1 D29). Some participants also received financial support with baby equipment.

A few of the participants described a change in the dynamics of relationships with their own mothers; for instance, some participants who reported that they had only intermittent contact with their mothers and not being that close. For these women contact changed as their pregnancies drew closer to full term and they received numerous telephone calls and enquiries about their well-being. Bernadette explained that her mum had been ringing up the previous three weeks or so and stated *'that's been*

really interesting for me to deal with. So that's definitely changed the dynamics there. (9.1 B62). These participants were a little cynical about the resumed interest in them because of their pregnancies.

Another perspective on relationships was presented by Dianne. She reported sometimes feeling a bit smothered in her relationship with her parents and added that now she *'felt even more smothered, being pregnant' (1.1 D49).* Other women depicted their relationship with their families as good. Nevertheless, one participant negotiated arrangements with her family for visiting after her baby was born to ensure she had space for developing a routine with her baby without having house guests.

Several participants had mothers who were living interstate or overseas. Some of these participants had plans for their mums to visit after their baby was born, however some were unsure about when they would be able to see their mum due to the complexity and costs of long distance travel. One participant had lost her mum to cancer during her pregnancy and she was upset and uncertain about how she would cope without her mother there for support.

Women's relationships with others

The final theme of women's experiences of relationships concerned the changed responses of other people to them, now they were pregnant. The most significant theme that emerged was the propensity some people felt to physically put their hands on the swollen abdomens of some participants. This was experienced by about one third of participants. Angela's recounts her experience here:

> *A lady just came up to me in the supermarket and she just started putting her hands all over on my stomach and she said "I love pregnant women" (laughter) and I just looked at her and I said 'oh.' I said um… 'Excuse me are you right?" and she said 'oh.' She said 'I love your belly.' I said 'Yeah, well so do I, but I don't really want you to touch it.' Like I didn't know her (laughs). Yeah, she was… that was bizarre. I sort of went out of the supermarket and thought 'Oh yuck, a stranger touched me' (laughter) (2.1 A.23).*

Another participant, Dianne, depicted her experience of strangers approaching and touching her. She related the conversation they had had and her response.

> *... 'Oh what a cute belly' or ..., 'How far along are you?' Nice comments. You know, 'You're looking really good.' It's never insulting or anything but it's still just, you know, 'Why are you touching me? You don't normally touch me' (12.1 D55).*

Dianne continued on to express that most of her friends would ask before they would touch her abdomen, which she did not mind. She explained that it was when people she did not know or when others grabbed or rubbed her on the tummy without asking that she found annoying and offensive (12.1 51-56).

Synthesis: Relationship Changes

During pregnancy, the existential tenets of lived other was significant as women's lived experience of others underwent some change. These changes occurred to different degrees but impacted on relationships with women's partners, their not-yet-born babies, their own mothers and with other people. Changes in women's relationship with their partners related to support provided and included extra household help, increased protectiveness, and increased communication; however, the degree of change varied between couples. For some couples, having a baby was seen as completing the relationship with their partner, making them more 'united'. Nonetheless, disclosing an unplanned pregnancy was awkward for women who were not in an ongoing relationship and involved much anxiety, uncertainty and procrastination. Women's experiences of the development of their relationship with their baby varied also. In some cases, the reality of their baby was crystallised during ultrasound assessment. Early confirming movements also contributed to this awareness, along with a developing sense of responsibility. Conversations with the baby and soothing the baby for sleep were other experiences that reflected women's emerging relationships with their not-yet-born infant.

A particularly significant aspect of women's lived experience of others was their relationship with their own mothers. Some mothers were supportive, offering emotional

support and providing practical help, such as assisting with housework. Those who had distant and estranged relationships with their own mother were surprised by renewed contact with them as their pregnancy neared term. Other women missed their own mothers who were separated by geographic distance or death.

Women also described changed relationships with people outside their immediate acquaintance. Total strangers would approach them and relate to them in ways that would usually be unacceptable, for example by touching their abdomen or making comments about their swollen belly.

Waiting

Waiting was a dominant theme for the pregnant women interviewed. This waiting involved a lot of time and was enmeshed and entangled with anticipation, excitement and some anxiety. Rose commented that being an expectant mother *'...just seems to be a lot of waiting (laughs). Waiting for the baby to come and anticipation and moments of excitement but also terror (laughs)' (5.1. R5)*. This waiting occurred at various stages of pregnancy. Themes revealed concerning waiting include: waiting to share the news, preparing for the new baby and the sense of being 'forever pregnant'.

Waiting to share the news

All women kept their pregnancy private initially. In the early weeks news of the pregnancy was generally only disclosed to parents or a very close friend. Most women waited until they had reached the three month stage when the threat of miscarriage was much reduced before sharing their pregnancy publicly. For these women the secret about their pregnancy was experienced as special and pleasurable and for most, *'a nice little secret to have' (2.1 A5).*

In contrast, Sarah's situation was complicated as she was not in an ongoing relationship with the father of her child. She waited until she reached 18 weeks of pregnancy before advising the father about her pregnancy. Sarah then waited again until 24 weeks

gestation before she broke the news to her parents, although she had confided in her older sister from the beginning. This was because Sarah was apprehensive about how her parents would react and felt guilty about disappointing them. Sarah experienced this secret as an uncomfortable one to hold for the four to five months she carried it. Her family were very supportive once they took in the news, and Sarah felt relieved to have it revealed.

For some women, however, they had to balance the desire to keep their pregnancy private in the early months with the risk of possible safety issues in the workplace. Bernadette was concerned about lifting heavy equipment that might be hazardous for her pregnancy. Similarly Ursula, a health worker, was concerned about potential involvement with aggressive or infectious patients. Both participants reluctantly disclosed their pregnancy to work colleagues early in their pregnancy in order to modify their duties slightly if situations presented a risk to their unborn babies.

Preparing for the new baby was an important component of the waiting time before birth. This included both informal and formal education and resting activities. A number of women spoke about a new attentiveness to other pregnant women and parents with young children. They discussed topics with other mothers that they had never previously been interested, for example: '*What's it like when…*' '*How are you coping?*'

Learning about birthing

Formal antenatal education classes were attended by most participants at one of three separate hospitals. At the antenatal interview all of the women were satisfied with the information provided. Bernadette described the classes as *'awesome'* and *'better than expected,'* although she thought the seven hours of education was a long time on the one day *(9.1 B96)*. Several participants attended another hospital where a series of two hour evening antenatal classes were run over a period of five weeks. A few participants reported that they felt the antenatal educators did not like to address questions relating to complications, which they termed their *'What if...'* questions. These questions were important to them because they felt it would give them an idea of what was happening if

a complication arose *(10.1 K61)*. For many of the participants one valuable thing about antenatal classes was having their partners there to listen and share the information. Another valuable outcome was seeing other expectant women and couples having a baby, sharing common experiences and seeing they were not alone. Several women commented that sharing a laugh in the sessions was also good. The antenatal classes were summed by Rose.

> *'Yeah its been good with some information we hadn't really thought of and its good to talk to other people about where they're at as well….and having a laugh. (5.1 R38-39).*

Most women felt the content of the sessions was great, exploring topics such as labour, types of drugs available, being in hospital, managing feeding issues (such as if the baby does not take to the breast) and taking the baby home. A few women had read widely and felt most of the content was familiar. A number of women reported the classes raised questions or issues that they had not considered, and this was helpful to them. Others commented that the classes were useful to ask questions about such things as their own diet and breastfeeding *(9.1 B97-98)*.

The hospital tour was seen as very useful by all participants who attended the antenatal classes. A number of women were surprised to find the birthing room was just a normal hospital room. For example, Gail shared that she had *'expected some big operation room' (6.1 G70)*. However, she described it as *'A lot better room than you'd just stay in as a patient. Like they had the double bed' (7.1 G71-73)*. Gail added the birth room was *'homely'* and that she felt she would be relaxed there *(7.1 G71-73)*.

Generally the participants who attended antenatal education classes found the labour and birth videos useful. A number of women shared that this made them feel so excited about having their baby and holding him/her for the first time. In contrast, one participant reported she felt very uncomfortable. Lee-ann attended antenatal classes but disclosed that she did not like discussing birth or watching the birthing videos. She was very clear that she did not want her baby to be placed on her abdomen or chest until it had been cleaned: *'I don't want to see all the icky [sic] mess that comes out with the*

baby (laughs). I do have a weak stomach on that. I haven't liked watching and hearing about births' (11.1 L85).

Only one study participant, (a sole parent) did not attend any formal antenatal education. Sarah declined to attend classes as she had family members who had recently had babies and she had spoken with them about childbirth. Also, she had also looked after babies and children a lot. Interestingly, Sarah attended a midwifery led model of antenatal care and also felt she had received adequate information from the midwife.

Preparing the Nest

Waiting for the new baby also involved preparations in the home. '*Preparing the nest'* was experienced as pleasurable, frustrating and stressful. For instance, when women needed assistance to move heavy furniture or boxes they found it frustrating if they had to wait for their partner to be available to assist. In addition, being pressured for time to prepare their nursery was experienced as stressful. Collecting items needed for their baby in contrast was generally very pleasurable and involved women in contemplation and reflection. Lee-ann, like the other participants, anticipated obtaining a lot of enjoyment in preparing the nursery for her new baby.

> *I've got a lot to look forward to these last four weeks of the pregnancy. We're setting up the nursery now... All of the nice new stuff. To unpack the new cot and new change table... I'm really looking forward to these last few weeks on that side of things (11.1 L60).*

Some participants shopped and prepared early, while others paced themselves throughout the pregnancy. Other parents had access to baby goods via extended family, some bought preloved items and some purchased new ones. For the couple who had moved from interstate mid pregnancy, shopping for their baby involved first finding out which places to go to and which stores to look at as there was some variation from other parts of Australia. The list of baby paraphernalia was extensive. All participants had a pram and somewhere for their baby to sleep organised weeks or months in advance. One couple had even purchased an antique cot prior to conception. Baby singlets and

jumpsuits were all lovingly washed and stored away in readiness for the not-yet-born baby. A few women had sewn some baby garments themselves and a number of women had been given baby clothes.

For the women still working, setting up the nursery was usually set aside for when they began their maternity leave. This was then experienced as a pressing item or concern until it had been completed. Some women, however, regretted getting everything ready early and felt that the final weeks of their pregnancy dragged without something to do. A number of women shared their experience of having completed all their preparations for their baby, but spending a lot of time just being in their baby's room: looking at tiny garments, moving linen or bedding or clothes around and gazing at the bassinet or cradle or cot. This reflective, contemplative time was an important part of waiting, as demonstrated by Jess:

> *...all the baby's clothes are set up and there's a cot and bassinet in there, the pram, baby's bath, blankets... and everything on the bassinet and cot… (laughs) (3.1 J96). Well I've got nothing to do during the day now… so I just go in there and play around for a few hours. Just rearranging the whole house. Looking at all the baby clothes (3.1 J97).*

Similarly Gail disclosed: *'I like being in a baby's room (laughing). You just go in and reorganise the clothes everyday (laughs). Just looking at it and think 'wow, we're going to have a baby in there' (7.1 G89)*.

'This pregnancy is going to go on forever and ever'

Waiting became more difficult as women approached their estimated due date of birth. Excitement and anticipation peaked as they grew tired of their heaviness and the discomforts of a term pregnancy. This time dragged for many women. For instance, Xerri's pregnancy extended ten days past her due date. During her second interview she disclosed that at the end of her pregnancy she felt tired and found it very hard *(1.2 X12)*. This is illustrated in this extract:

I was just getting so anxious and I was over it. I could not sleep properly and I just could not do anything. I was having trouble just going for a walk without feeling completely buggered by the end of the street… I think, having to wait for bubs to come out... I felt like it was never going to come. I just felt like this baby… this pregnancy is going to go on forever and ever... I started feeling very hopeless. I just could not get things done and I was so tired… (1.2 X12-16).

The excitement and impatience of family and friends also wore participants down. Angela explained that once the due *'day comes and goes then the phone calls start' (2.1 A29).* She related that she spent one afternoon gardening with her husband and had 18 messages on her answering machine when they went inside. Person after person had phoned to enquire how she was going and if she was in hospital having her baby as she had not answered the phone *(2.1 A29)*. Similarly Xerri's frustration with waiting was exacerbated by friends and family telephoning to enquire about her well-being: *'The phone was ringing constantly 'Have you had the baby yet?' (1.2 X20)*. Eventually Xerri decided to take the phone off the hook as she just wanted to be left alone.

'It would be my aunty or somebody. 'Haven't you had the baby yet? Are you having contractions? Has this happened or has that happened? Oh you're probably going to be having it soon if you're having that kind of pain'' (1.2 X20-21).

Like many of the other participants Sarah felt frustrated by her pregnancy extending past her due date. She noted in her journal:

The baby still is not here yet and I'm getting even more frustrated as the days go on. I really thought that I would have had the baby last Friday but it did not happen… I was disappointed with myself because I had not gone into labour…I just thought I could do it by myself (Sarah's Journal pp. 9-10).

Sarah was also frustrated by encouragement and requests from family and friends to have her baby on a certain day. She sought solitude and a warm comfortable place to give birth to her baby. This journal entry captures a picture of what she yearned for:

I just wish I could be like a cat and disappear into a warm dark place and have the baby without them knowing, then appear a couple of days later with the baby. And they would all shut up and leave me alone (Sarah's Journal pp. 11-12).

As her pregnancy continued past her due date Sarah wrote:

The baby isn't here!!... I have not had any more pains since Tuesday night and it's really getting to me….. I had another appointment … and [the hospital] said …if I have not gone into labour by Monday … they will think about inducing me (Sarah's Journal p 14).

Synthesis: Waiting

The antenatal period revealed the existential tenets of lived time, lived other and lived space as being involved in the insight of waiting. Waiting was enmeshed and entangled with anticipation, excitement and anxiety, and occupied a lot of time. News of the pregnancy may initially only be shared with close family and friends and public announcement postponed until after the risk of miscarriage is reduced. Preparing for the new baby is another important component of waiting. Women shared a new attentiveness and interest in expectant and new mothers and how they managed and shared learning about birth and mothering in education classes with their partners and other expectant couples. Preparing a place at home for the new baby involved contemplation, reflection and anticipated joy. In the last weeks if pregnancy waiting for the baby to be born became tiresome and difficult and women perceived that they were going to be pregnant forever. Unrelenting enquiries from family and friends about signs of approaching labour exacerbated frustration with waiting.

Wondering

The theme of wondering was the final theme identified concerning participants' lived experiences of pregnancy. At the time of the pregnancy interviews participants had left paid employment and were heavily pregnant. There were numerous questions they held in their thoughts as they contemplated motherhood. This section will explore women's

concerns wondering about death, loss, labour and birth, their baby and themselves as a mother.

Wondering about Death, Loss and New Life

A number of women shared recent experiences of grief and loss either around the time their child was conceived or during their pregnancy. Four women experienced bereavement. For three participants this involved the death of a grandparent they were very close to, and for another it was the death of her own mother. One of the women who had suffered the death of a grandparent, Lee-ann, wondered about the interconnectedness of life and death and new life. Lee-ann described her pregnancy as *'a blessing' (11.1 L24)*. It was confirmed only a week or two after her grandfather died and she depicted it as *'almost like there was an ending of one life and a starting of another' (11.1 L24)*.

Angela's mother died in the early months of her pregnancy. Angela was pleased to have shared the news of her pregnancy with her and know that her mother had been thrilled. Nevertheless, when her mother died Angela felt anguished. She wondered how she would manage a new baby without her support: *'...when we had to bury mum ... I was thinking it was the worst thing in the world... I thought 'God, how am I going to cope with a baby? And I'm not going to have my mum there' (2.1 A6)*. Angela explained this was: *'Because you need your mum there, as a bit of support network and we were really close, really close' (2.1 A6)*. Angela went on to relate that she has a great husband and fantastic friends and that her mother's sisters were all around and hence felt that she had a good support network *(2.1 A6)*.

Four other participants had their mother living interstate or overseas. While the mothers of two participants planned to visit soon after birth, the other women prepared for childbirth knowing that their mothers would not be nearby for advice or support.

Other kinds of grief and loss affected some of the participants as they contemplated becoming a mother. For two of the participants it was the postponement of career opportunities because of their pregnancies. Jess became a mother instead of a tertiary

student but had a partner supporting her as she prepared for motherhood. Sarah did not have an ongoing romantic relationship with the father of her baby. Although she did not wish to burden the father of her baby she wanted him to enjoy whatever level of involvement he wished to pursue with their child. *'... I suppose the biggest thing I'm concerned about at the moment is the father and what he wants to do ...' (4.1 S51).* Sarah struggled to get a direct response from this man, and was left wondering at the uncertainty. The lack of certainty or clarity made it difficult for Sarah to plan her future. She wondered if the father of her baby wanted to be involved with her child and if he wanted to have any input at all.

Wondering about labour and birth

Most participants found not knowing when their baby was going to come and what was going to happen with the birth left them with many things to ponder and wonder about. The anticipation grew more intense as the due date drew closer. Wondering about birth tended to also include unease about where the woman's partner or birth support person would be when labour began. Kate captured the essence of many participants' wondering about labour and birth. *'The anticipation is getting greater and greater. When's it going to happen? How's it going to go? (laughs). Is he going to be at work? (laughs)' (10.1 K135).*

Women also reported a multitude of other questions and apprehensions that occupied their minds at this time. Some of these are illustrated in the comments shared by Xerri:

> *...I'd be laying in bed all the night thinking 'When is this baby going to come'? or 'I've just had a niggle, Is that the start of things?' It was just hard not knowing when it was going to happen. And not knowing what was going to happen during the birth. That was the hardest part, I think... (2.1 X16).*

Several women had particular anxieties concerning how they would cope with labour and birth. For instance, Lee-ann admitted that *'I'm petrified of it. I'm absolutely petrified. ...I have been so worried about that through the entire pregnancy. I am worried that I'm not going to be able to cope with the pain' (11.1 L77).* She struggled

with the conundrum of being afraid she would not be able to cope with the pain of labour but at the same time not wanting to have any drugs. She also articulated her fears about epidural analgesia:

> *I do not want to take any drugs that are going to transfer to the baby. And I do not want a needle in my back because I'm worried about, you know, losing the ability to walk in case they get it in the wrong spot. You know, all those scary sorts of things. And that has worried me a lot. Immensely (11.1 L77).*

The prospect of epidural analgesia during labour was an area of particular concern to a number of participants. Hayley shared that she was *'really scared'* of having an epidural. She explained: *'I've got multiple sclerosis in my family so I was really worried about spinal things...' (13.2 H40)*. In a similar vein Kate had been adamant throughout her pregnancy that she did not *'want anything having (sic) to do with [her] spine.'* She declared *'[She] was scared to death of it' (10.2 K46)*. Bernadette also was concerned about possibly requiring an epidural. She revealed: *'And because my spine is a bit dodgy I was really, really concerned about it... I was thinking 'I don't want to end up paraplegic ...' (9.2 B46)*. Bernadette gave her x-rays and CT scans to her doctor in advance so he knew which areas to choose if he had to insert an epidural.

Some participants had heard horrific stories about the labours of their mother or a sister or a friend. Wondering what their own experience would be like was something else that women reflected about. Kate shared that she hoped for a normal labour*: 'I'm scared to death of needles (laughs) so I do not want anyone coming near me with a catheter or anything. I'm hoping I can cope with it without much assistance from needles' (10.1 K51).*

Wondering about the baby

None of the participants had any medical concerns about the health of their baby at the time of the first interview. One participant had been advised about the gender of her baby, but the other participants did not know whether their babies were male or female. These women spent a lot of time pondering about this and all the women wondered

what their babies would be like. Bernadette, in particular, found this interesting and intriguing and captured the essence of this theme:

> *I feel (my baby move) all the time, but to think that I'm going to be a mum within a few weeks is quite a surreal feeling. And to sort of not know anything about our child is strange ...to not know the hair colour or the gender or anything like that is quite strange when it's a part of me (9.1 B2).*

All of the participants were very keen to finally meet their baby, to see his or her face, and also the little hands and feet that kicked inside them. Women also wondered and worried about the wellbeing of their not-yet-born babies. This concern for their baby was entangled in awareness of the uncertainty of labour and also their own wellbeing. Xerri captured the concerns of most participants in the following except:

> *...Just wondering: Is everything was going to be all right? Is the baby going to be healthy? And am I going to be all right? Am I going to pull through it? ... am I going to have a caesarean? What's going to happen? ... Am I going to be able to breast feed? Is the baby going to have nappy rash flat out? (1.2 X16-17).*

Wondering about myself as a mother

A number of women spoke about being more reflective as their pregnancy approached term. The idea of becoming a mother became more real for the participants in the study as the time drew near for them to give birth. Women reported an array of thoughts and feelings as they wondered about themselves as a mother. Jess was interviewed when she was 37 weeks pregnant, and offered this honest response about what being a mother was like for her. She confessed: *'...it's a bit daunting. Like I've got used to the idea but it's still a bit overwhelming' (3.1 J4)*. She reasoned that was probably because her baby had not yet arrived. For Jess feeling daunted also revolved around her being a younger mother: *'I'm only eighteen and I'm still my mum's baby. And I'm only a child'* (3.1 J6).

The experience of feeling somewhat daunted was shared by many of the other participants. A few of the women participating in the study had been involved with children in some way, but many of the women shared that they had not had anything

much to do with children before. Dianne, 34, was an only child and neither she nor her husband had much to do with children. She revealed, *'I've never even changed a nappy on a baby, let alone have one*' (sic) *(12.1 D88)*. While Dianne was very much looking forward to having her baby, she wondered about how she would be as a mother.

> *It's a bit scary at the moment. I'm excited but I'm scared. Not about the labour but about the 'whatever after' bit. Like how am I going to cope in the first year or two years? I [do not] really have a clue because I'm an only child… I do not really know what to expect. I have not been around a lot of babies and stuff. So that's a bit nerve racking but I'm just hoping I'm going to be a good parent (12.1 D1).*

The interviews attempted to explore what participants were thinking about when they reflected on their babies and their roles as mothers. A number of women tried to grapple with the concept of early motherhood and tried to understand what made it difficult. Dianne's reflection crystallises some of this wondering and trepidation.

> *Everyone says 'oh it's so hard' and you know it's going to be hard but you really do not have any idea why or how. Like you do not know what to expect. You know you're not going to have any sleep and you know it's going to be chaos but you cannot quite imagine how bad it is that people describe it. Like you think 'Oh it cannot be that bad' but then it must be because everyone says it is … So it's more anticipating and trying to figure out what it's really going to be like… (12.1 D65).*

The theme of wondering about themselves as a mother permeated all the interviews. Women wondered about knowing what to do and being able to work out how to manage different responsibilities as a mother. Gail reflected on aspects of being a mother that she presumed would be challenging. Her summation expressed thoughts shared by most of the other participants:

> *Challenges [sic] I reckon will be trying to figure out why it's crying and if something's wrong how to fix it and try and figure out what is wrong… Or… will I know what's wrong? Or if something is wrong what happens if you do not know? (7.1 G88).*

Synthesis: Wondering

The final insight of 'wondering' reflected van Manen's existential tenets of lived other, lived body and lived time (1997). Women held a number of questions in their minds as their pregnancies progressed. Family bereavements caused reflection on life and death and a wondering about the interconnectedness of life with the ending on one life and the beginning of another. As the birthing time drew near musings and wonderings washed over women: When would labour start? Would their partner be with them? How would the labour progress? Women also wondered and worried about their not-yet-born babies. Wondering if they would be alright, wondering if they would be healthy, if they would be able to breastfeed. Increasing reflections crystallised the trepidation some women experienced. Women tried to imagine what being a mother was going to be like and what they would be like as a mother.

Conclusion

This chapter has reported on the insights of this study concerning living the transition from woman to pregnant mother. Major themes identified as underpinning women's experiences at this stage of early motherhood were: life changes, living the physical and emotional experience of pregnancy, relationships, waiting and wondering. Each of these themes has been explored and supported by interview data. A synthesis summarises each of the major insights. Women's experiences in each of these areas varied, reflecting the individual nature of the lived experience of pregnancy. The next chapter will present the insights from this study related to participants' experience of labour and birth.

Chapter 6

Labour and Birth:

'The hardest thing I have ever done'

Introduction

Participants' experiences of motherhood during the antenatal period were explored in the previous chapter. This chapter follows on and reports the study insights concerning participant's experiences of labour and birth. The second interview with participants generally occurred two weeks after the participants had given birth and consistent with the initial interview, women were asked about their experience of being a mother at that time. Each participant shared their story of labour and their experience of giving birth. The key themes that emerged were: the experience of labour, managing pain during labour, support to get through labour and birth, the incredible effort of second stage, the first meeting, there was all that blood, and birth in a technological age.

Is Something Happening?

Uncertainty and doubt clouded participants' recognition of early labour. Labour began spontaneously at home for most of the participants. Some participants began labour with mild contractions and some experienced initial confusion in recognising they were beginning labour. For instance, Xerri experienced irregular *'gastricky pains'* and related that *'I honestly thought I'd had something bad to eat.'* She presented at the hospital for review of her gastric pains at 41.3 weeks gestation. Xerri relates that she was surprised to be told that *'it wasn't the Chinese food'* causing her *'gastric'* pains but that she was in labour and her cervix had dilated 5 centimetres (1.2 X12).

Most participants described early labour as *'not too bad ... like period pains'* (1.2 X26). Several participants related that they did not think they were in labour as their

experience *'wasn't like how [they had] read [about] in books'* (2.2 A12). Angela had been having intermittent contractions for weeks and shared that '*I just thought they [the contractions] were Braxton Hicks again* (2.2 A2).'

Participants described being in a range of circumstances or activities at the time their membranes ruptured. These included being at home, being in bed, at the letter box, feeding the cat, doing the ironing and sneezing. The most common place was being in bed, either at home or at the hospital. Some participants recognised the spontaneous rupture of their membranes as indicating the possibility of labour beginning soon. Others thought they had wet themselves. For instance, Christie described the sensation as *'a hot, damp ...wet'* sensation and wondered if she had lost control of her bladder (6.3 C11). Jess related: *'my water broke and I had no idea what that was ... I thought I was just wetting my pants'.* She noted *'bits of blood and stuff'* when she went to the toilet so telephoned her mother (3.2 J9-10).

Gail similarly compared the experience of her waters breaking to feeling *'like you sort of wet yourself because I was in bed and when I stood up it came straight out down my legs. It was like someone had a hose on me...'* (7.2 G37). At the time, however, Gail actually did not think that her waters had broken as the fluid kept *'going and going and going'* (7.2 G36). She thought when the *'waters broke'* that it happened and then stopped. In contrast another participant was uncertain if her waters had broken as she experienced loss of only a small amount of fluid. She shared: *'I expected a huge gush like a bucket of water or something, but it wasn't ...'* (6.3 C11). Hayley returned to bed after going to the toilet and experienced her waters breaking as she was sneezing. She described a sensation of wetness and commented: *'It didn't really feel like urine or anything like that .... Almost like a period but not ... like a lot more fluid than a period'* (13.3 H117). Another participant described losing the mucous *'plug'* or *'show' and having 'a little bit of leaking, but a slow, slow leak'* (10.2 K6-7).

Synthesis: Is this something happening?

The existential tenant of lived body (Van Manen 1997) frames women's insights of early labour. Confusion and uncertainty pervaded the recognition of the onset of labour. Women were hesitant and unsure if their 'waters had broken' as they perceived the

changes in their bodies as being different to the descriptions recalled from books or education classes.

The Experience of Labour

Following on from participants' individual experiences of early labour and the spontaneous rupture of membranes, these women's descriptions and experiences of uterine contractions and stronger labour were also unique. These insights are reported around the themes of *'the pains started ...'* and *'it's getting stronger'*.

Contractions: 'The pains started...'

A number of participants found it hard to describe the sensation of the contractions. Gail said it was an *'odd'* or *'weird pain.'* She described: *'it's like someone's sort of grabbed you in the stomach and then holds you, and then stops'* (7.2 G42). Bernadette related that for her *'it was like a cross between just burning and intense muscle contraction ...It was a real burn like lactic acid once you've run up a mountain too quick and you've got a cramp sort of pain... an overwhelming pain'* (7.2 B44-45). She noted that while the pain was *'overwhelming'* and *'all consuming'*, it was a pain that she knew would finish soon (9.2 B61).

Angela added that: *'You can't describe the pain. It's something ... no book can tell you what a contraction is really like or what labour is really like'* (2.2 A11). Angela affirms that contractions and labour did not match what she had read about in books. She expected a wave of pain that would start at the top of her uterus and progress down, but she did not experience it like that. She shared:

> *It started from side to side for me. Like either side of my hips and it started off like a period type cramp and would just get really intense and build and build and build. And you'd be thinking to yourself 'come on, come on, go back down', and then you would feel it when it started to subside and then you'd have that little bit of break in between (2.2 A12).*

The participants described a variety of locations in which they experienced their contractions. Most women experienced the pain very low in their abdomen and in their back. A few women reported feeling the contraction pains more on one side, or all over their stomach. Participants did, however, describe the pains as getting stronger and more intense as labour progressed. Kate noted that her contractions lasted *'anywhere from a few seconds to about 30 seconds'* but that towards the end they felt like *'an absolute eternity'* (10.2 K30-32). As Kate explained initially her contractions were kind of static but that later they began *'building and then tapering down'* when there was a lull until the next one. Kate compared her initial contractions to *'really bad period pain'* but notes that towards the end of her labour they were intensified *'a hundredfold'* (10.2 K24).

'It's getting stronger'

The description of labour pain as an intense pain multiplied by a hundred or million fold was used by several participants to quantify the potency of the pain. All participants who had a vaginal birth described the experience of strong labour as very arduous. For instance, Xerri described this as:

> *...hard, because at that stage it felt like I was having like one contraction after the other. ...one would ease up, and I'd think 'Oh, beautiful that's over' and then bang 'Oh no, thiscan't be happening again, it's just too soon, isn't there a break in between'?... (1.2 X35).*

There were, however, certain events that intensified the contractions. Angela's membranes were ruptured artificially at the end of the first stage of her labour. She noted that once her membranes were ruptured her contractions *'became so intense'*, adding they were:

> *...sort of harder, sort of, stronger, longer as well. ...it was like a period pain times by about one hundred. ... and my legs were shaking and I ...kept getting cramps in the feet and I couldn't figure out why, and my aunty ...said every time a contraction was coming she could tell and she'd look at my toes and they were curling uptight (laughs) (2.2 A52).*

Angela continued her description of her experience of strong labour:

> *I had really sore hands… [from] holding so tightly onto a railing the whole time. …and towards the end I found that my breathing was, it was all over the place. I couldn't control myself. …and the part I didn't like was that I felt totally out of control at the end, …you have no control over it because you know that one's over and 'Oh my God' you could feel that tightening starting to happen, and you thought 'Oh, here comes another one now' (2.2 A53).*

Participants who underwent epidural analgesia said they no longer felt physical pain and were able to sleep or have conversations during the established or later phases of their labour. Jess related that *'it was scary'* watching the contractions peak on the foetal monitoring (CTG) machine as it was *'going up to 100'* (3.2 J14) and she was glad she could not feel it.

Several participants commented on the importance to them of maintaining a sense of staying in control during labour or having a shared control with their midwives and doctor. Ursula declined the offer of Pethidine analgesia as she *'didn't want to feel out of control'* (8.2 U46). She stated: *'I needed as much strength and my wits about me to keep going for as long as I did'* (8.2 U49). Bernadette shared that she would ask: 'what's going on now?' (9.2 B34) and the midwives would tell her. She related: *'It really helped with the pain as I knew what was going on all the time and they were so in control that I felt totally safe the whole time'* (9.2 B34).

Half of the participants who progressed to vaginal births experienced labours that lasted more than 21 hours (range 21 to 48 hours). One such example was Hayley whose labour began with the spontaneous rupture of her membranes and the simultaneous onset of five minute contractions. She attended the hospital soon after, as advised, due to requiring antibiotic treatment. After hours of labour Hayley described feeling *'really over it'* (13.2 H52). She elaborated further:

> *[I] just couldn't see the other end. Just couldn't see the light at the end of the tunnel or anything … Just couldn't see anything come out of it because it had just gone on for so long. … And I was just thinking 'I've been through all this, how long is it going to take to get further' 13.2 H54-55).*

After being told she had only progressed to 3cm dilation of her cervix she said: *'I just thought I can't go through this anymore'* (13.2 H59) and opted for epidural pain relief.

Managing Pain during Labour

There were a number of general strategies used by participants to manage the labour pain. Some participants used these strategies to progress to vaginal births without epidural anaesthesia; other participants employed them to manage their pain prior to accepting epidural anaesthesia. There were two sub themes observed: some women worked with the pain using simple measures while others struggled against the pain.

General Support Measures

Ursula, for example planned how she wanted to manage her labour using general support measures. She expounds: *'I'd got music, had music playing all the time. I had hot packs. I had Gatorade, I'd planned it really well'* (8.2 U45). Hayley described watching *'Video Hits'* on the television during the early part of her labour (13.2 H32). She also remembers *'having contractions and walking around'* (13.3 H123). A number of participants had showers to help reduce their experience of pain. Some had been sceptical about the benefits of hot water initially but soon changed:

> *...I had a shower which helped. I was quite surprised because I know they do say that and I thought 'oh yeah, what's hot water going to do'? (laughs). So but yeah it does. It calms you down and it does help (7.2 G43).*

Other approaches participants explored in managing the pain of their labours included: back massage, hot packs, walking around, and talking about *'nothing'* as a distraction. Several participants were assisted in managing their labour pain by having a support person counting aloud through contractions. This is illustrated by the following excerpt:

> *...Dave was counting. So he'd count ten, nine, eight, with the contractions. So when I got to five already I was thinking 'oh good' (laughs) (9.2 B61). ...so that was a really good method for me. ...he'd count and that's all I had to focus on (9.2 B62).*

For other participants having someone coach and model a focussed breathing pattern helped them through their contractions (2.2 A53). Christie described her experience of using *'self-talk'* (6.3 C22) to manage the pain of her labour. She shared that she was talking to herself the whole time:

> *I was thinking… all women that have babies have gone through this. And I'm just thinking I can get through this …you know, I was talking to myself a lot in my head (6.3 C21). …With the pain when it got a bit stronger I kind of, just rise (sic) above it type of thing. Like you know its coming and then you just think 'well if I can just think outside of this pain and then come back down it will be sort of gone' (6.3 C14).*

Christie continued on to relate how she experienced her contractions differently to what she had heard in antenatal classes. She had been advised that contractions became closer and closer together and ultimately caused pain lasting a *'full one minute with minimal break'* (6.3 C14). However, in her experience of labour Christie observed *'it was more the peak of the contraction that was painful'* (6.3 C166). She focused her mind on getting through the height of the contraction by the following: '*[I would] ride through it and know if I can just get my mind over this, (6.3 C167)… then I'll get a little bit of a break…' (16.3 C15,17).* Christie accepted that there would be another contraction to come, and reframed this experience as *'and each one will be closer to her being born …' (6.3 C167).*

Menu of Medical Pain Relief

Most participants however were not able to work with the pain throughout the whole of their labour and used some, or the entire spectrum of medical pain relief available to them. The menu of medical pain relief options began with gas (nitrous oxide and oxygen), then narcotic analgesia such as Pethidine or Morphine, and then epidural analgesia. One participant refused narcotic analgesia, and another was too advanced in labour to be able to have it when she requested it. Two participants reported having adverse effects from the injected medications of Pethidine and Phenergan, causing excessive vomiting and sedation (1.2 X40).

Most participants who used the gas analgesia found it helpful, at least in the early stages of established labour. This experience is captured by Sarah's observation: *'I liked the gas. Even though it dried my throat out and made me cough it was good. ...just having the mouthpiece and breathing and that was good' (4.2 S24-25).* This idea of holding the mouthpiece and focussing on breathing was further explicated by other participants. For example, Rose shared:

> *...I had gas and I think for me… it helped me regulate my breathing and concentrate on the breathing, (sic) so I could focus on breathing rather than focus on the pain. ...I don't think the gas really helped but it helped me focus on the breathing properly which helped the pain (5.2 Rose 24).*

In contrast, Sarah noted the gas *'made [her]* go woozy'. She experimented to see if the gas actually made a difference by trying alternate contractions without the gas and eventually decided when she did not have the gas the pain hurt a lot more. Sarah concluded the gas *'took the edge off the [pain]'...* (4.2 S25), adding that the contractions *'...weren't as intense'* when she used the gas. Sarah described it: *'I felt like I'd… just smoked a joint or something like that, like marijuana. Sort of gave you that woozy feeling, but apart from that, yeah it was good'* (4.2 S29).

For a few participants, however using the gas was experienced as difficult. One participant said she could not hold the gas as she was *'squeezing'* her mother's and partner's hands … *'they were holding it for me and it made my face all tingly and I was really sleepy'* (3.2 J17). She related that she would forget to tell them to take it away, and it made her *'feel a bit sick'* (3.2 J18). Gail revealed that she did not know what she was saying when using the gas, and that she had been talking about past boyfriends (7.2 G69). Another participant, Christie reported she had some difficulty as described in the following extract:

> *...with the gas… you are meant to breathe in and out but I wasn't doing that because I was thinking 'I've got to get this gas into me' (laughs). ...I found the gas really good because it was a distraction from the pain. It didn't take the pain away but it makes you think of your breathing… it must have got me a bit airy-fairy, yeah. Because I remember at one stage you'd hear people talking in the room and it was just… you weren't tuned in to what people were saying… (6.3 C18).*

Only a few women commented on their experience of using narcotic analgesia. Xerri was offered some Pethidine when she *'...was just starting to get a bit frazzled and starting to climb the walls'*. She commented that she *'didn't like it...It made me too sleepy'* (1.2 X22). Rose was given Pethidine in the last hour of her labour after her labour had seemed to slow. She related that it was given to help relax her pelvic area and that the labour progressed on from there (5.2 R 29).

Jess used the gas initially and said: *'...that didn't work. And then I asked for Pethidine and that didn't help, and then I asked for the epidural'* (3.2 J13). Hayley had a Morphine injection for pain relief some time into her labour, after her labour was augmented with a Syntocinon infusion. She felt *'really over it and hoping to get some sleep'* (13.2 H 37). Hayley became quite distressed with the pain despite the Morphine and stated: *'By that stage I was… asking for a caesarean… so we ended up having an epidural'* (13.2 H 38). Insights regarding women's experiences of epidural analgesia are discussed later in this chapter along with other technological interventions.

A number of participants described experiencing a sense of altered consciousness and physical ability during the later stage of their labour following some medical pain relief. Xerri describes feeling exhausted and *'zonked'* between contractions. She said: *'I was literally being dragged around the bed by everyone because I couldn't move. ...* (1.2 X39). Xerri explained she could hear everyone talking about her:

> *Hearing everyone say 'Oh, maybe we should put her hair up or maybe we should get her a drink, maybe we should get her a flannel'. But not being able to say 'No, I don't want any of that, leave me alone, get this baby out', ...I had no energy (1.2 X41).*

Christie outlined a slightly different experience. She told of being aware of people around her but not fully aware of whom was speaking or what was being said. She gives an example of hearing a *'blah blah blah blah sound'* and her mum's *'blah blah blah blah'* in reply and thinking *'oh it's someone talking to mum'* (6.3 C27). Christie also described being cognisant of comfort measures such as patting and heat packs. She revealed that while she appreciated the physical comfort measures rendered to her and mentally expressed thanks, she was unable to verbalise this in words (6.3 C19).

Time as a Paradox

A number of participants experienced time as a paradox. For instance Jess recounts that she went in to hospital and *'before I knew it I had her'*. She reflected that although *'afterwards it felt like [time] had gone so fast, but [it] also dragged at the same time…' (3.2 J133).* Jess explained that she waited expectantly for the midwives to say *'you're 10 cm dilated, you can start pushing now (laughing)…' (3.2 J133);* however there was a long period of waiting before that occurred. In a similar vein Xerri captures her experience of time during labour noting: *'the time flew but it felt forever... I had no concept of what the time was' (1.2 X34)*. In addition, Xerri described losing a lot of time due to the effects of Pethidine and continued *'it felt like it was just forever, it was a bit of a black out period there' (1.2 X34).*

In contrast, Kate described an intense anticipation to meet her baby. Her labour initially went slowly, but time passed quickly from when the epidural was commenced (10.2 K147-150). Kate attributes this to the anticipation of meeting her baby: *'Come on, come on, get out already, come on, (laughs). It's time to meet you, get out' (10.2 K153).*

Likewise, other participants observed that time dragged initially in the early stages of their labour and then seemed to pass more quickly when their contractions increased (4.2 S97-98). Christie was focussed in her mind telling herself that '*it won't be much longer*' and related that *'although I was going all day, to me it didn't feel like that. It felt really quick'* (6.3 C23). Similarly Bernadette experienced a 24 hour labour but says: *'it honestly didn't feel like that. I was exhausted and I was hungry'* (9.2 B57). Bernadette describes the time span of her labour at the hospital: *'we got there in the dark, then it was day time and it was night time again'* (9.2 B52). Overall, however, Bernadette experienced time as passing 'really quickly.'

Long labours were not uncommon in this group of women as can be seen. Hayley experienced *'quite a few shifts of nurses, probably five or six'* (13.2 H35) and described her 43 hour hospital labour as a *'marathon'* (13.2 H90). In contrast Angela had a 12 hour labour that progressed quickly initially, but then experienced a drawn out second

stage of labour that lasted almost four hours. Angela confessed being preoccupied with the time. At this point of the labour she described the intense contractions rolling on top of one other and each minute seeming like an hour.

> *...I was obsessed with the time… I kept saying 'What's the time now'? and they hid the clock in the end (laughs). Because, you know, a minute felt like an hour. And then they put the drip in [with] Syntocinon, which was horrible because you had no relief in between the contractions. So it was just like they were rolling on top of one another (2.2 A16).*

This experience of time during late labour was echoed by Kate who described the strong contractions as seeming like an *'eternity (laughs). An absolute eternity'* (10.2 K32). The preoccupation with time during labour was also articulated by other participants. Bernadette gave an account of how her husband did not tell her what the time was. She later commented this was 'smart' as she was trying to mentally forecast her labour in advance. However, the labour had progressed much more slowly than she predicted:

> *... I was trying to sort of think 'well in two hours, or at the end of the two hours I'm going to push and I'm going to…' in my head. But it had actually been you know, another six or so (laughs)… (9.2 B51).*

Overall, time was experienced differently for participants during labour. It often dragged during early labour or as participants dealt with strong contractions however, paradoxically time was experienced as having *'gone so fast'* overall.

Synthesis: The Experience of Labour

The existential tenants of lived body and lived time (Van Manen 1997) were evident as labour advanced. The sensation of uterine contractions was difficult to describe but the pain and duration of these intensified as labour progressed and contractions would build to a peak and then taper down. The pain was all consuming and unrelenting but women knew that it was a pain that had a cycle and would end. Strong labour was an arduous and challenging experience. It was physically consuming and impacted on the whole body; producing shaking legs, cramping feet, breathing disordered by distress, a sense of loss of control and despondency for some with long labours. Women initially used a

range of physical and psychological measures to manage the pain, but most participants later progressed to use the spectrum of medical pain relief options. Time was generally experienced differently during labour, with time dragging in early labour and then progressing quickly as contractions increased.

‘Support to get through it’

Participants were supported during labour by a range of people. All the women who had partners were supported by their partner. The participant who was single was supported by her mother. In addition, some participants were also supported by their mother, a friend or another family member.

The Woman’s Support Team

A number of participants reported that their partners were supportive in helping them cope with the pain of contractions. They described how their partners talked with them, played relaxing music, dimmed the lighting in the room, rendered physical comfort and bolstered their spirits. Gail related that her partner, Bob, stayed with her at the hospital when she was admitted for induction. He slept on the couch as he did not did not want to leave her. This was reported by Gail as being reassuring to her, and meant more to her than him being there for the labour as it showed a genuine commitment to be there with her. As her labour began Bob helped Gail *‘breathe properly’*, sat with her, and *‘told me to hold his hand if that hurt (sic).’* Gail indicated *‘he was just constantly thinking about me… and making sure that I was calm and relaxed. He was really good through it, really, really good’* (7.2 G40).
ow to calm me down.’

This kind of support was provided by several other partners. For example, Ursula described how her husband John packed her up in the bed with heat packs so she could rest. Ursula explained that she would not have otherwise been able to rest: *‘The only thing I could do was lean against the bedside table [or use] my gym ball …. He was really good. I wouldn’t have been able to [rest on the bed] without those hot packs’* (8.2

U46). Ursula summed up her experience of support from her husband saying *'He was very attentive with everything'* (8.2 U55). She shared: *'He knew how to massage my back; he knew what I wanted without me really having to say'* (8.23 U57).

While a number of participants described their partners as very supportive, a few experienced their partners as being present but uncertain how to be supportive or overwhelmed by the situation. Others described their partner as preoccupied watching television. These participants then described how support from family and friends helped them get through their labour. Angela shared that she had to have someone with her to help focus her breathing. She described how her brother provided this support: *'my brother was fantastic and he'd stand there and go 'Wo wo wo wo' [makes noise of breathing] just to remind me because otherwise… I found that my breathing was all over the place. I couldn't control myself…'* (2.2 A53). As previously mentioned, Angela experienced a difficult and prolonged second stage of labour that lasted almost four hours. She divulged that her brother was stalwart in providing staunch emotional support, when her other support people succumbed to personal distress in response to her prolonged suffering and anguish:

> *I had my brother this side and he was really good in the end because he was the only one who [was not upset]. My husband was upset; my aunty was upset, so they were all crying. Even one of the midwives was crying (2.2 A20).*

Professional Support

Most participants were satisfied with the support of their midwife or midwives during their labour. Participants valued midwifery care that kept them informed of their progress, offered comfort measures and reassurance and provided support for managing pain. For example, Bernadette was *'euphoric'* about the support she experienced from the midwives caring for her. She continued on to affirm:

> *...it was just incredible … the birth on the human side was totally mind blowing. Like those women [midwives] really, really added to me having a brilliant birth. [It] could have been quite traumatic considering what had happened and I didn't leave feeling traumatised. … It really helped with the pain because I knew what was going*

on all the time and they were so in control that I just felt totally safe the whole time... (9.2 B34).

Bernadette experienced a prolonged labour, vacuum assisted birth and postpartum haemorrhage. Despite these complications Bernadette describes feeling supported and safe, aware that her midwives were in control and getting her and her child through her labour and birth.

There were only rare instances where women reported feeling unsupported by midwives during their labour. One example occurred where a participant reported that the midwife caring for them in early labour appeared more interested in watching television than supporting them. In another example, a participant described being frustrated with her midwives because she felt they were lying to her about her progress during a prolonged second stage of labour. She related:

...I knew something was going on because the three midwives and the obstetrician were all talking to one another and I kept saying to them 'What's going on'? and (laughs) they were saying 'You're doing really well' and I said 'You're all liars.' (laughing) (2.2 A17).

She felt quite exasperated with her situation and progress. This is illustrated in this excerpt:

...I got quite distressed in the end. ...I was pushing and pushing and I kept watching the midwives and ... in the end they were whispering to each ... I was getting more and more upset every time I'd push. And I'd say 'Has it moved? Has it moved'? and they'd say 'Yeah, you're doing well' and I'd say [imitating an indignant, sorrowful yelling] 'Bullshit! It's not even coming out' (laughing)… (2.2 A10).

While participants reported General Practitioners or obstetricians as only briefly present during the first stage of labour, all participants had a doctor present at the moment their child was born. Three participants were attended by a specialist obstetrician, two by an obstetric registrar, and the remainder by general practitioners with diplomas in obstetrics. About half the participants mentioned the doctor present at delivery by name

and had a patient-doctor relationship with their accoucheur during their pregnancy via antenatal clinic care.

Christie was the only private patient in the cohort and she related the experience of *'waiting'* for her doctor to travel from Melbourne to be present for the birth of her baby. He had said he would be back at the district hospital about 5 pm.

> *...I remember at one point I was kind of going against the contractions. ...And I thought I can't keep doing this. But in my back of my mind I know I was thinking of [my doctor]. Thinking he'll be back soon and I want to wait until he's here. I knew that's what I was doing… (6.3 C35).*

In their accounts of their experience of labour and birth, about half of the participants described incidents where they had moments of intense connection with their attending doctor. These interactions included intense eye contact, feeling listened to, and feeling empowered. Angela related her experience of being empowered to find that last measure of strength to push her baby into the world by the eye contact and encouragement of her doctor:

> *I think they were talking about prepping me for a Caesar because I kept saying 'I can't do it, I can't push anymore.' And I was physically… exhausted by the end of it. And then I just looked at the obstetrician and she said to me … 'You can do it, come on put your mind to it' and I thought 'Oh bugger it.' And I pushed and pushed and pushed and I managed to get him out in the end (2.2 A18).*

In a similar vein Bernadette described feeling affirmed by her doctor's support of her desire to persist through a protracted and gruelling labour. She had wanted to avoid a caesarean birth and believed that his belief that she did not have to have a caesarean changed the whole birth course. She recounted her doctor said *'all right if you think you can do it then we'll keep on going.'* Bernadette shared: *'[This] really changed the whole birth potential as well. Like it could have been traumatic'* (9.2 B34). This support was experienced as very positive and empowering for this participant.

The support from doctors, however, was not always experienced by participants as optimal. One participant divulged an incident where she felt taken advantage of. The

situation involved her doctor bringing a medical student into the labour room to perform a vaginal examination on her. She reported her doctor saying to the student: *'[Patient's name] is so easy going. Don't worry about it. Get on your knees' (laughs)* (9.2 B37). However the woman did not feel comfortable about this and felt dehumanised. She related: *'I was thinking, you know, 'this is not on, just because I'm easy going… I feel like a cow' (laughs) (9.2 B37).* However she brushed it off and felt that *'…out of twenty-four hours, twenty minutes … was pretty good to be grumpy' (9.2 B37).*

For this cohort of participants this incident of a woman having a negative experience of support from her doctor was isolated. Participants were overwhelmingly appreciative of attempts by medical staff to manage the care of themselves and their unborn babies. However, the women participating in this study experienced a long list of interventions and complications during labour and childbirth and the immediate postpartum period. For the thirteen participants this included: one vaginal haematoma requiring surgical drains and vaginal packing, one spinal puncture requiring a blood patch, two emergency caesarean deliveries, three third degree tears, four inductions of labour, five postpartum haemorrhages, seven epidural or spinal anaesthetics, and eight instrumental deliveries. These all seemed to be perceived by the individual participants experiencing them as bad luck.

Synthesis: Support to get through it.

The existential tenant of lived other or lived relationship (van Manen 1997) was also important during labour. Support from a partner via personal connection, encouragement to keep going and a sustaining presence was at the core of getting through labour. Attentive concern, caring conversation and receiving physical comfort created a reassuring and safe atmosphere to labour in. Some mothers, mothers-in-law, brothers and aunts also supported women during labour. Women valued the care of midwives in getting them through one of the hardest times in their lives. They also appreciated being informed about the progress of labour and management options and felt protected and in safe hands to observe midwives in control. While doctors were only briefly present during the first stages of women's labour, all participants had a doctor present when they gave birth to their child. Several women described moments

of intense communication with their doctor during the labour or birth: deep eye contact, feeling listened to or being affirmed.

Nearing Birth: The Incredible Effort of Second Stage

The study insights concerning women's experiences of the second stage of labour were centred on the themes of incredible maternal effort, the sense of achievement in giving birth, the wonder of the first meeting between a mother and her baby and the amount of blood associated with birth.

Maternal Effort

Three participants in this cohort experienced a spontaneous vaginal birth. Vaginal births for the remaining eight participants occurred in the context of epidural analgesia and instrumental (vacuum extraction or obstetric forceps) delivery. (See Appendix 14).

The second stage of labour was described by participants as very intense. Angela articulated that:

> *It was just a lot more intense than I thought… you'd be having a contraction and they'd be telling you to push (laughs) so you'd be in pain from the contraction and you'd try and virtually push against the contraction. …so that was really difficult (2.2 A54).*

The pushing with contractions to birth the baby was described as an intensely physical task. Angela detailed her experience: *'And I pushed and pushed and pushed and I managed to get him out in the end' (2.2 A18).* Participants related being *'physically exhausted by the end of it' (2.2 A18).* Christie described knowing the baby's head was down low and being able to feel how big it was and thinking *'so that's got to come out through there, well I'm going to have to push hard' (6.3 C152).* She reported that her support person observed that she was pushing so hard that her eyes were rolling back in her head (6.3 C38). Other participants similarly reported the extreme and concentrated effort involved in traversing through the second stage of labour. For instance, Bernadette described her travail:

It was quite painful … but I got to a point in my head where the pain was a good pain. Like that push just meant that the baby was coming …Like I just thought 'no I'll just push with everything even my eyeballs until he comes out' and he did. I was tired, but it was good (9.2 B33).

Those who were able to experience sensations at this stage described the urge to push with contractions as *'that intense pressure down there' (2.2 A25), 'like I needed to go to the toilet'* and being *'worried that I was going to do something' (5.2 R 33).* Rose described the feeling as like *'a primal thing, like really bearing down.'* Rose shared that she had not thought about making any noise at that stage but that she *'just relaxed and let go'* and that *'the noise seemed to help' (5.2 R 33).* Christie recalled shouting *'Come on'!* in her head, like Lleyton Hewitt the tennis star, as she gave the last push to birth her baby into the world. Others also described the powerful surge of energy at this stage of the birthing process as *'a burst of energy [that] came from nowhere'* once they were told the baby had crowned (1.2 X42).

Participants provided frank descriptions of the sensations involved with the physical birth of the baby. Angela relates feeling an *'intense pressure down there,'* wanting to *'just get it out'* and the contradiction of being told to pant. She questioned: 'How can you pant at a time like that'? (2.2 A25). Participants described an awareness of the baby's head coming out and a '*wonderfu*l' sensation of '*relie*f' (2.2 A25) and '*release from pain*' once the baby's head was delivered (2.2 R 39; 6.3 C38). Gail gave birth in a supported standing position, held under her arms by her husband. She expressed her memory of this stage of her labour: *'I just remember looking down and seeing her head and sort of went 'Oh my God that's her head! She's out'!* She asserts this feeling *'just kept me going then'* (7.2 G48).

The delivery of the baby's body was generally reported as not as intense or challenging as pushing to crown and then deliver the baby's head. Christie's baby had to have the cord cut from around her neck, but after that the baby *'just slipped out'* (6.3 C38). This was reiterated by Rose who depicted the sensation of the birth of the baby's body as being *'like a slippery sausage coming out. All wet …[with] a gush of water … as well' (5.2 R 35).*

Each of the participants who had epidural analgesia progressed to have an instrumental or surgical delivery of their baby. Most experienced a vacuum or obstetric forceps delivery, while two had emergency caesarean births. Many of those having instrumental deliveries reported difficulty or inability to feel the contractions during the second stage of labour. Bernadette sums this up: *'It was confusing after the epidural because I didn't know which muscles were what. And my brain wouldn't associate parts of my body properly so that was difficult' (9.2 B33).* Hayley similarly explained this: *'I still couldn't…I could just feel my contractions but I don't think I could feel well enough to really push and she ended up having suction and then forceps to be delivered' (13.2 H66).*

Sense of Achievement

A strong theme in participants' accounts of their birth experience was a sense of achievement. Rose shared her feelings *'I had achieved… gone through the hardest thing I'd ever gone through and come out the other end still in one piece'* (5.2 R 55). Kate was triumphant and astounded when her baby was placed on her chest and asked *'Oh God! What did I just do'? (10.2 K73)*.

A number of other participants described feeling amazed, stunned and lost for words. Gail commented; *'Oh my God, wow!… that's something that we've done together and something we will always share together' (7.2 G66). '...it's something we created' (7.2 G58).* Xerri commented '*I was very proud. I was rapt that I did it… I was just overwhelmed.'* She shared that she actually said that to everyone that was present in the labour ward: *'I've done it! I gave birth! I can't believe it'! (1.2 X38).*

The Wonderful First Meeting

For the majority of participants the first meeting with their newborn was 'wonderful'. For some, however, it was marred, by maternal exhaustion or briefly postponed by neonatal resuscitation. Study participants described different experiences of meeting with their baby in the immediate moments after giving birth. Participants described

having their baby put on to their chest, their stomach, taken away for resuscitation, presented to them over an operating theatre screen, or if birthing in a hands and knees position, placed on their back or passed between their legs. Hayley noted that although she had nine months to think about the moment of her baby's birth that '*nothing really prepares you for it… there's no way of knowing what to expect*' (13.3 H131).

This moment of first meeting was described by a number of participants as a *'wow'* moment that was *'incredible,' 'wonderful,' 'ecstatic,' 'beautiful'* or *'surreal.'* It was accompanied by tears from some of the women giving birth, their partners, many midwives and some doctors. Christie shared that *'I was just so elated and happy and excited'* (6.3 C40). Some women depicted the experience of meeting their baby and realising they had given birth as a pinnacle of achievement. Gail was astounded and exclaimed: *'Oh my God, I've just given birth'!* (7.2 G49). Christie cried: *'I've done it… I just feel really, really good'* (6.3 C41). For others the achievement was accompanied by amazement and incredulity.

Unfortunately, several babies had to be taken immediately to the resuscitation crib for assessment, suctioning of their airways or administration of oxygen. Two mothers reported feeling not concerned at that stage. Christie, for example reported: *'I didn't really tune in that she could have been in distress or trouble… I was just so happy that I had a little girl'* (6.3 C40). Ursula similarly related that her baby was taken away to be suctioned, and '*I knew they were doing something to her but I wasn't too worried about that'* (8.2 U66). In contrast other participants reported feeling distressed to have their baby taken over to the resuscitation crib. Gail shared: *'they took her to the little crib thing… I just remember sitting there looking at them thinking 'oh God, what's wrong, what's wrong''?* (7.2 G50). Gail commented that although the time may have only been three or four minutes it seemed much longer *'when you're sitting there waiting for her it was about an hour. '...come on, come on'* (7.2 G51).

For other participants, however, the first meeting with their baby was characterised by *'exhaustion.'* Angela explained that after her baby was placed on her stomach she *'didn't even have the energy to lift up [his] arms to see what he was'* (2.2 A23). Similarly, Jess related being instructed to look at her baby. She described responding with an *'oh'* and then fell back down on the bed feeling *'exhausted'* (3.2 J21). One

mother could not see her baby being attended to at the resuscitation crib until she was moved over to a chair. She recounts:

> *I just sat there exhausted and bleeding and just felt dazed… I wasn't worried about holding her or anything like that. So there wasn't that bonding session that I expected… It's just horrible, isn't it? I just felt like I was bleeding (8.2 U67-69).*

This response was also echoed by some of the other participants. Bernadette described seeing her baby and thinking *'Oh okay, you're here and this is who you are.'* She notes that she did not '*get that instant 'oh ...you're my baby sort of feeling''* that she expected, rather she just felt *'a bit flat' (9.2 B630)*. Hayley noted that she had expected to cry when her baby was born but that after a prolonged labour: *'I think I was just over everything by the time I had her' (13.2 H146).*

Many participants reported a strong change in their focus once their baby was born. A number of participants described feeling fervent relief. Angela described her response when her baby was finally born as: *'Relief. Big time relief'* (2.2 A63). Angela continued on to describe her emotions at the time of birth as *'exciting'* and *'overwhelming.'* She noted: *'It's amazing how… I found I just felt protective of him straight away'* (2.2 A63). Gail shared: '*you're not thinking about the pain when you're sitting there looking at your baby*' (7.2 G54). She related that she was *'just stunned.'* She says her emotions were *'full on…They just run wild on you.'* (7.2 G54). *... [she was] something we created. Something we will always share between the two of us.'* Several mothers commented on the notion of finally meeting the '*inside baby*' after nurturing him or her for the nine month gestation period. Christie encapsulates this emotion : *'Oh it was just beautiful having her… because she was just on my body and I just couldn't believe that I was holding the little thing that had been inside me all that time'* (6.3 C44). Others shared the surreal sensation of meeting *'the little person that you haven't met yet'* (9.2 B63).

This intensity of emotions continued when the participants got to hold their babies. For example, Gail described being given her baby to hold for the first time after she was resuscitated; *'they turned around and gave her to us and that was overwhelming'* (7.2 G53). Gail shared that she was very emotional and *'just kept looking at her'* (7.2 G58).

Kate added holding her baby for the first time was '*wonderful and a little bit scary. You don't quite know what you are doing but you do know what you are doing…'* (10.2 K103).

Some participants related that it was a while before they were able to hold their baby and take it all in. Angela cannot remember what she felt when she held her baby for the first time. This was because he was passed to others to hold while she received sutures and then her Dad and her brothers *'had a hold.'* It was about an hour after the birth when the midwife encouraged her to feed her baby and she '*got to have a good look at him*.' Angela described this as a nice time to share as *'I felt like I hadn't… met him…'* She explained that up until that time she had been tired, so this meeting allowed her to have a good look at him (2.2 A65).

Initial Impressions of Baby

A number of participants described the various first impressions they had of their newly born child. Xerri described her newborn as a *'beautiful baby'* even though she was '*still covered in blood*' when she first met her (1.2 X79). She offered a rich picture of their first meeting:

> *...she was so calm when she was born. She didn't scream or anything. She cried but as soon as they put her on my chest she calmed down straight away and then when Thomas spoke to her she just stopped, and just looked up at us and she was so alert* (1.2 X79-80).

In addition, Xerri emphasised that her baby *'was a very pretty baby'* and that she had *'such a pretty little face'* (1.2 X79-80). Similarly, Kate's initial impression of her baby was that she was *'warm and soft… bloody'* (10.2 K74). She described her baby as a *'beautiful, healthy little creature'* (10.2 K83). Others shared that their baby '*was wide eyed when she came out*' (8.2 U71).

On the other hand, Gail related that her first impression of her baby was that *'she was really blue from the nose around the mouth' (7.2 G50).* Gail's midwife sat with her and reassured her that the cord had been tight and they were '*fixing the baby up'* (7.2 G50-

51). After she was given her baby to hold. Gail related that she was initially stunned. She expressed amazement and wonder: *'Wow!... She was inside me! I just gave birth to her!...'* She encapsulated her experience of motherhood in the following observation: *'[this]...little baby that we created, that has grown inside me for nine months and she's here for the rest of our lives now' (7.2 G58).* Gail added that she felt overwhelmed with emotion and sat there gazing intently at her newborn baby. Other participants also expressed astonishment to be holding their baby. Christie said it was *'beautiful'* to have her baby. She shared that it was hard to believe she was '*holding the little thing that had been inside me all that time'* (6.3 C44).

In contrast, Lee-ann's initial response to her baby was relief that she was okay. She was shown her baby when she was first born by caesarean but then the baby was taken away to be dried and checked. This suited Lee-ann as she did not want to hold her newborn while she was *'all gooey and yucky and that sort of stuff'* (11.2 L39). She was pleased to have the midwives '*clean her up'* first and to hold her when she was *'nice and alert'* herself. As soon as she was transferred from the recovery room to the ward Lee-ann requested to hold her baby and related that she *'was as proud as punch'* (11.2 L39).

'There was all that Blood …'

Several of the participants who had vaginal deliveries described surprise at the amount of blood present after the birth of their baby. In all except one case this was reported by participants who experienced normal blood loss at birth, not those who experienced postpartum haemorrhages. Rose said she was not worried by it, but was just surprised: *'When there was all that blood… and just the smell of blood, I just wasn't expecting that.' (5.2 R44)* Rose was encouraged to share more about '*the smell of blood*' in the interview, but only added: *'I can't describe it but in the moment it was like that is the smell of blood' (5.2 R 44-45).*

Another participant recounted that *'mine was a really messy birth and… I was losing a lot of blood.'* She shared that her husband said that it *'was like a massacre in there at one stage.'* This was surprising to her as it was something that no one had ever mentioned to her (2.2 A26). Similarly Ursula, who did have a postpartum haemorrhage,

described the labour room *'It just looked like a war scene, blood everywhere.'* After birthing her baby in a hands and knees position with the assistance of vacuum Ursula was sat in a chair while her baby was examined and then admired by her extended family. She said '*I just kept bleeding and bleeding and bleeding. They estimated 600 or 700ml loss… I didn't care that they were all in the room but I just wanted to stop this bleeding a bit'* (8.2 U76-79).

Several participants shared their yearning for a shower in the immediate post birth period. Rose commented that she was not expecting all that blood and *'just wanted to wash that off and feel clean and hold her [baby] properly'* (5.2 Rose 43). Angela described her experience of her shower after her baby was born: *'It was beautiful. It was so warm and you could just sit on a chair and you know, every bit of you hurt basically… it was just nice to sit there and to feel clean again* (2.2 A26).

It is appropriate at this stage to summarise the birth outcomes. All participants progressed to have healthy term babies, who were initially breastfed, had good 5 minute Apgar scores and weighed an average of 3,486g (range 2,940 to 4,200g). The women themselves, however, did experience significant intervention and complications. Summaries of maternal and infant outcomes are recorded in Appendix 14.

Synthesis: Nearing Birth - The Incredible Effort of Second Stage

The physicality of the labour experience peaked as the birth drew near. Concentrated effort was required in the second stage of labour to endure the pain of powerful contractions while strenuously working to push the baby down the birth canal. A primal bearing down eventually birthed the baby's head with an amazing sense of relief and release. Birthing of the body was usually uneventful as the remainder off the baby emerged wet and slippery with a gush of fluid. Newly born infants were placed in various locations depending on the mother's birthing position and their wellbeing. The existential tenant of lived relationship (van Manen 1997) underpinned the first meeting between mother and child. For most participants this was characterised by wonder, elation and incredulity that the baby had arrived. Others, however, felt exhausted, dazed or flat after a prolonged labour or complicated birth and didn't have any energy left to hold or engage with their baby. Overall newborn babies were perceived as warm,

soft and beautiful, when introduced to their mothers, even if still covered in blood. For most women giving birth was a proud achievement; they had endured the most challenging endeavour of their lives so far. The amount of blood accompanying childbirth surprised many women, who described a continuum from 'messy' to 'like a war scene'. Women yearned for a shower.

The Changing Face of Normal: Birthing in a Technological Age

The study insights concerning women's experiences of birthing interventions are explored next. These include getting labour going, being confined, epidural anaesthesia, instrumental birth and 'off to theatre'

'Getting labour going …'

Almost one third of the women in this cohort had their labour induced or underwent attempted induction of labour. The indications given for induction of labour for these participants were hypertension or pre-eclampsia. Three of the participants whoF were induced were at 40 to 40.3 weeks gestation when their babies were born. Only one participant was induced before being 40 weeks gestation, and she was 37.5 weeks gestation when her child was born.

Induction of labour, as experienced by the participants in this study, was generally a slow process. For some participants the induction was preceded by ripening of the cervix either by the use of Prostaglandin tape or gel. Ripening of the cervix is a process that makes the cervix more suitable for an induction (Fraser and Cooper 2009). This process was reported by the participants as not always being straight forward.

Gail, for example, had the Prostaglandin tape inserted to her cervix but became very distressed by the sudden intense pain when she began having contractions a few hours later. She related that: '*It was just one after the other. There was no break, no nothing'* (7.2 G28). Gail told the midwives that she '*couldn't handle the pain, [and] needed something because it was just constant and wearing [her] out'* (7.2 G29). She reported

that the midwives then removed the tape and the contractions stopped. Gail went on to have a spontaneous rupture of her membranes several hours later, and began contracting spontaneously early the next morning. A similar experience occurred with Ursula with whom ripening of the cervix was also attempted. Ursula had the Prostaglandin tape inserted early in the morning but related that it came away after her membranes ruptured spontaneously that night. She experienced irregular contractions overnight and the following morning was given an intravenous infusion of Syntocinon to stimulate her labour.

Another participant experienced trans-vaginal insertion of prostaglandin tape to her cervix on three separate occasions, over three days before commencing labour. Rose related that she *'wasn't expecting anything to happen because nothing had happened the previous times… [but when she] 'started getting twinges, contractions… [she] got all energised'* (5.2 R 14). Rose was delighted to finally begin labour and was moved to the labour room.

Lee-ann was admitted to hospital with pre-eclampsia and was told that as her kidneys were beginning to not function well she needed to have her labour induced. Lee-ann had the prostaglandin tape inserted on two occasions over two days and then received intravenous Syntocinon on the fourth day. She related that *'all the days really dragged on'* (11.2 L148). Her fiancée took time off work to be with her during the induction and labour and she recounts: '*They kept saying 'we're going to induce you today, so it should happen today' and for four days we had that…'* (11.2 L148). She articulated that she was really annoyed that her partner had taken so much time off work from his casual position for so many days, when the induction was ineffective. On the fourth day, after the commencement of the Syntocinon infusion, Lee-ann began having five minutely contractions for about one hour. Her doctors decided to halt the induction and deliver her baby by Caesarean section as her baby's head remained high above the pelvic brim and she had a slightly narrow pelvic inlet measured on ultrasound (11.2 L13-15).

The induction of labour by intravenous infusion of Syntocinon stimulates the uterus to contract and is administered via increasing increments in dosage until labour is established (MacDonald and Magill-Cuerden 2011). Two participants in this study

underwent this intervention following unsuccessful cervical ripening via the cervical tape or gel. Participants were generally unsettled or anxious about the process of having their labour induced. For instance, Ursula shared: *'I very much wanted a natural birth'* (8.2 U29). For Ursula, there were a lot of issues associated with being induced. She stated *'I was dead against being induced… I didn't want to be attached to a drip and be restricted, I wanted to be able to move around'* (8.2 37). Ursula was also aware of her sister's experience of *'a full on labour'* after being induced. She described how support from the midwives helped her process the concerns she had. In addition, Ursula said she was also helped by calming herself, self-talk to be strong, exploring her preferences with staff and by staff sharing the pros and cons of each option. Ursula progressed to manage her labour without drugs and admitted: *'I thought it would be easier (laughs), but it was full on' (8.2 U45).* She refused Pethidine for pain relief as she did not want to feel out of control. After the birth she said she was happy with how her labour proceeded as she had planned it really well (8.2 U 46-47).

Augmentation of labour was an intervention experienced by half of the participants. This procedure aims to speeds up the labour process where it has already begun. Augmentation of labour can be surgical, where the amniotic membranes are artificially ruptured with an instrument such as an amnihook or amniotomy forceps. This involves insertion of the instrument trans-vaginally up to the cervix and the piercing of the amniotic sack. The amniotic fluid drains out and the progress of labour is enhanced (Fraser and Cooper 2009). If the membranes are already ruptured but progress is deemed slow then augmentation of labour may be initiated. This involves intravenous infusion of Syntocinon to stimulate the uterus to contract. For labouring women having their labour augmented the infusion is administered in increasing increments in dosage until strong labour is established.

Participants in this study who had their labour augmenteded described varying experiences. For instance, Angela reported being in second stage of labour for four hours. After she had been pushing for 2 ½ hours her labour was augmented with a Syntocinon infusion. Angela described this experience saying *'the Syntocinon [drip] was horrible because you had no relief in between the contractions. So it was like they were rolling on top of one another'* (2.2 A16). Sarah was also given a Syntocinon infusion to augment her labour after 10 hours of contractions. Her membranes had been

ruptured for over 24 hours and her cervix had dilated to 4 centimetres. She relates that the infusion was stopped about 5 minutes after it was initiated as her baby's heart rate slowed with each contraction.

A similar augmentation occurred for Christie, whose waters broke at home on her due date. She was admitted to hospital and began mild irregular contractions overnight but was not in established labour. The following morning her midwives encouraged her to walk around to stimulate labour. However when her doctor arrived in the morning he adopted a more medical approach and augmented her labour with an intravenous Syntocinon infusion advising that *'they didn't want infection to set in.' (6.3 C3).* This was not comfortable for Christie who reflected:

> *...the ...thing that annoyed me with going on that drip thing was I was expecting I'd be able to… walk around and do all that... when I was in labour. But I was confined to a small area because the drip was in my arm and the [foetal] monitor thing around my tummy (6.3 C14).*

The risk of infection likewise altered the events for Hayley's labour which began with the spontaneous onset of 5 minutely contractions and ruptured membranes at home at 40.2 weeks. Due to carrying a Streptococcal infection she had to attend the hospital straight away to begin antibiotics. Her labour progressed slowly. After some time her labour was augmented with Syntocinon infusion, but 36 hours after beginning labour, the IV line needed to be re-sited as she was in severe distress and only three centimetres dilated. Hayley was given an epidural, the Syntocinon was restarted and her baby was born after a total of 43 hours of labour via an attempted vacuum and then obstetric forceps birth (13.2 H37).

Confined: Tied up for monitoring

Half of the cohort commented on undergoing foetal monitoring of their baby during late pregnancy or labour through the use of a cardiotocograph (CTG) machine. The technology of external foetal monitoring used with this group involved attaching sensors to the upper part of the pregnant women's abdomen to record uterine activity and over the lower abdomen to record the foetal heart rate. These sensors were held in

place with straps, and are connected to the machine by leads. The machines monitored the response of the foetal heart rate to the uterine contractions on a graph. Interpretation of these graphs provides insight concerning foetal wellbeing and foetal distress (Pairman et al 2010).

The main issue with foetal monitoring reported by most participants was having their movements confined as they had to be seated or lying down during the procedure. Where monitoring was used briefly to assess onset of contractions and foetal heart rate pattern, it was less problematic. On the other hand, where it was used daily, it was irksome. Lee-ann underwent foetal monitoring daily during her antenatal hospital admission. She commented that the foetal monitoring was an:

> *irritating thing because you had this stupid machine on you for half an hour at a time. Busting to go to the toilet,… it wasn't until they put the machine on you that you decided you need to go to the toilet* (11.2 L145).

Participants who were connected to the foetal monitoring machine during their labour also described experiencing it as restrictive. Christie shared that *'I was thinking I'd be able to walk around [during labour] and go in the shower'* (6.3 C139). She noted, however, that she was confined to a small area because of the intravenous infusion and foetal monitoring (6.3 C14).

In addition, some of the participants disclosed increased anxiety and worry associated with the use of the CTG machine during labour. For instance, Jess reported '*I was just laying there watching the monitor'* (3.2 J13). She watched the graph of her uterine contractions and *'it was like going up to one hundred and it was scary'* (3.2 J14). Jess had an epidural anaesthesia and commented that she was glad she could not feel the contractions. Sarah's baby experienced some foetal distress during labour and the foetal heart rate would drop to about 80 bpm during her contractions and rise again after the contractions eased. The normal range for foetal heart rate is 110 to 160 beats per minute (Fraser & Cooper 2009). Sarah shared: *'I started to get worried at about four o'clock when it kept dropping to about 80 and that's when they called [the obstetrician].'* Sarah noted that the midwives tried to minimise her awareness of the situation *'they wouldn't*

*let me see the machine and they turned the heart rate… noise down so I couldn't hear it' (*4.2 S8).

Women's Experience of Epidurals

Over half of the participants in this study experienced epidural analgesia or anaesthesia during the labour or birth of their baby. Epidural anaesthesia is produced by the injection of a local anaesthetic into the epidural space of the lumbar or sacral region of the spine, inducing regional anaesthesia from the abdomen, pelvis or genital areas downward. Thus epidurals are used to manage pain during childbirth. An epidural is distinguished from a spinal anaesthesia where anaesthetic is injected beneath the arachnoid membrane that surrounds the spinal cord, which can also be used to control pain during childbirth (MacDonald & Magill-Cuerden 2011). All participants who had an epidural during labour progressed to have instrumental or assisted births. Two participants required emergency caesarean births. Four participants experienced instrumental deliveries which included vacuum extraction and obstetric forceps, while one participant experienced partial vacuum extraction only and then progressed to deliver her baby herself from the crowning stage.

Concerns about Epidural Analgesia

Jess, the youngest study participant at 18 years of age, was very distressed by the pain of her labour. During her labour, Jess had initially tried the obstetric gas and Pethidine analgesia, but found them insufficient to manage her pain. She requested and received epidural analgesia early in her labour which effectively controlled her pain. After the epidural, Jess noted that she felt scared watching the monitor that measured the strength of her contractions and shared: *'it was scary and I was like [sic] glad I can't feel this' (3.2 J14).*

In contrast, the other six participants had epidural analgesia as part of managing prolonged labours or for emergency caesarean deliveries (epidural anaesthesia). Most of these participants entered labour with a keen desire to avoid an epidural, and clearly

articulated fears of the potential side effects of epidurals. Participants expressed strong and clear concerns about the fear of accidental spinal injury, spinal damage, paralysis and paraplegia. In addition, these women articulated apprehension and anxiety about fear of *'that needle'* and pain associated with the procedure, and expressed it as being *'scared to death of it'* (10.2 K46), and feeling *'really petrified'* (11.2 L18). Other concerns held by participants related to their ability to remain still during the procedure while in labour (4.2 S32; 11.2 L23), personal history of orthopaedic spinal damage (9.2 B46) or family history of multiple sclerosis (13.2 H40).

Women's physical experiences of epidural analgesia

For participants who had a prolonged labour, the epidural was usually administered at the stage when the women felt quite exhausted and distressed. Some participants required considerable persuasion to consent to an epidural, while others were very ready to accept the relief offered. For instance, Kate vehemently rejected the option of an epidural when made by her doctors, but then related that: '*I went on for a little bit longer and I think I realised myself that I just couldn't do it anymore. So I said 'I don't care, just do it''* (10.2 K160).

Likewise, Hayley commented that when she had her epidural inserted that: *'I was sort of at breaking point...'* (13.3 H124). Bernadette was similarly exhausted. She said: *'I honestly don't think I could have gone through that any longer after sixteen hours of it... I was pleading with Dave saying 'Dave you know me (laughs) I can't deal with this anymore''* (9.2 B48-49).

Study participants offered rich descriptions of the physical experience of having an epidural anaesthetic inserted and their experience of this type of pain control during their labours. Several participants described feeling the local anaesthetic **'***as a little prick***.'** Lee-ann relates that:

> *...once the local was in it was fine I didn't move at all. I made sure my breathing was really strong and steady so that I didn't hold my breath or move or twitch when they were putting the needle in* (11.2 L23).

Hayley revealed that she felt *'the stinging of the local [anaesthetic] to begin with'* but then after that '*didn't feel any pains at all'* (13.2 H42-44). She explained that she was *'quite confined'* after having the epidural because of the need for regular monitoring of her blood pressure and other medical attachments. Hayley detailed being connected to *'the CTG monitor, two drip lines and then an epidural as well'* (10.2 H44).

The level of sensation following the epidural varied slightly between participants who had the epidural for management of labour pain. Some participants described having some sensation such as *'pins and needles'* or legs feeling *'like lead weights'* or the sense that their legs were *'very fast asleep',* others described a perception of numbness. All participants who had an epidural analgesia reported a full block in terms of a complete cessation from feeling the pain associated with uterine contractions. Most participants reported going to sleep and being able to relax. Bernadette noted the epidural gave her an opportunity to not be overwhelmed by the pain and gave her time to refocus on her goal of a vaginal birth (9.2 B51).

The participants who went on to have vaginal births assisted by forceps or vacuum extraction described difficulty pushing during the second stage of their labour. For instance, Jess related: *'...it was really hard to try and push her out when they were saying 'push'... I didn't feel the urges... I felt like my face was going to burst'* (3.2 J15-16). Kate commented: *'I don't know how I did it'* (10.2 K50). Hayley's words sum up the difficulty of trying to push with contractions to give birth to a baby when the sensation of the contractions is suppressed or partially suppressed: *'I could just feel my contractions but I don't think I could feel well enough to really push and she ended up having suction and then forceps to be delivered'* (13.2 H66).

Sarah shared a very detailed description of her experience of having an epidural inserted, which in her case occurred immediately prior to having surgery for an emergency caesarean birth. She said:

> *I just remember the prick of the local anaesthetic or whatever they give you. ...I didn't feel him put the spinal block in I just felt him sort of like poking me in the back. And then obviously once he put it in and injected it, it just felt like I suppose what it would feel like if you fell through a frozen lake. I just went instantly cold. And*

that's when I said to [the midwife] 'I'm cold, I'm cold, I'm cold' and she said 'yeah, you're just going numb, it's all right.' And yeah, I was freezing, like my teeth were chattering coz just instantly from half way down my chest just went cold (4.2 S34).

From this experience, Sarah explained that she felt frightened: *'I just thought you went numb, I didn't know you went cold like that. And that's when they started layering warm blankets [on me]'* (4.2 S35). Sarah added that she no longer felt the strong labour contractions she had been experiencing immediately prior to the insertion of the epidural, and instead

I didn't feel anything else after that. Like I felt them touching me but I couldn't… distinguish whether it was sharp or blunt. Whether it was just them tugging, I couldn't feel anything like that. ...I could feel them touching but that was about it. Yeah I didn't even know that she'd cut me (4.2 S 40).

Likewise, Lee-ann, who underwent a caesarean section described being aware of *'pulling and pressure'* (11.2 L25). She added that: *'You could feel everything but there was no pain… you could feel your whole body sort of jerking around because of their pushing and prodding'* (101.2 L26).

The participants, who were extremely reluctant and fearful about having an epidural prior to being in strong labour, changed their views about epidurals after their personal experience during labour. For example, Sarah commented that *'having the spinal wasn't as bad as I thought'* (4.2 S33). Bernadette was pleased as her epidural wore off and her doctor performed a partial vacuum extraction of her baby and allowed her to birth her baby herself from the crowning stage. She summed up her perspective as *'I didn't want an epidural but I love them now'* (9.3 B144). Kate experienced a third degree tear and related that *'I don't think I would have handled that very well without the epidural'* (10.2 K39). Later in her interview when asked how she felt about epidurals afterwards she said: *'I sing the praises of the epidural'* (10.2 K132). Likewise Lee-ann commented that she would *'definitely have another one again… It was terrific… Being alert… you could feel everything [with the caesarean] but there was no pain'* (11.2 L25-26).

It is noted that complications for this cohort seem to be more commonly associated with epidural anaesthesia than labours where this method of pain relief was not used. One

participant experienced a spinal puncture following the epidural and had a severe headache that persisted for several weeks after the birth of her baby. In the early postnatal period she had to lie flat in bed because of the severe pain. A majority of the participants having an epidural also experienced a postpartum haemorrhage.

'You need some help …' Instrumental Births

Most participants who progressed to a vaginal delivery were assisted by instruments. Participants' stories and experiences of instrumental delivery varied significantly according to the progress of the labour and uterine position of their baby. For the three participants who did not have epidural analgesia, the use of vacuum extraction to facilitate the delivery was not problematic. Xerri documents that the vacuum delivery she experienced was almost not required following a three hour second stage of labour. *'I… got this burst of energy right at the end and the doctor actually said he didn't really need the vacuum in the end… [it] just sort of guided her out a bit'* (1.2 X42). Likewise, Angela experienced a delayed second stage of labour, and was being considered for a caesarean delivery. She was experiencing increasing distress, and shared: *'I was physically… exhausted by the end of it.'* Her obstetrician attempted to do a vacuum delivery but Angela told her *'to piss off with that'* (2.2 A18). After some intense eye contact and encouragement from her doctor, Angela increased her efforts and birthed her baby herself (2.2 A18). Similarly Ursula had a long labour of 26 hours and required assistance from the vacuum to complete second stage.

As previously described, all participants who underwent epidural analgesia had births assisted by vacuum extraction or obstetric forceps with various outcomes. For instance, Jess experienced a failed vacuum and the birth of her baby was then assisted by the use of obstetric forceps. She commented that *'they couldn't get a strong enough grip on her head because of the way she was coming down in my pelvis and they had to grab the forceps and pull her out'* (3.2 J29). Similarly Kate shared that her baby was pulled part of the way with the vacuum and then delivered the rest of the way with obstetric forceps (10.2 K51-52). She commented that at the moment of birth *'I just forgot about everything… when they placed her on me…'* (10.2 K72-73).

The experience of instrumental delivery was described as *'pretty rough'* and '*all fairly traumatic'* by Dianne (12.2 D4). Dianne was transferred to the operating theatre for the attempt at instrumental delivery of her baby who was in a posterior position and 'stuck' (12.2 D22, D4). In addition, Dianne explained that the birth was then complicated by shoulder dystocia *'because he was twisted and the shoulders got stuck. So that's why they cut me so much to get him out'* (12.2 D32).

In this case, the baby suffered mild cerebral trauma, needed oxygen and suctioning but established respirations within one minute. After being examined he was placed on Dianne's chest. He was very *'cranky'* for the first week due to the mild cerebral irritation (12.2 D23). Dianne herself had a large episiotomy which extended to a third degree perineal tear and a post partum haemorrhage. Consequently, Dianne required a urinary catheter, perineal wound drains, two vaginal packs and intravenous lines for antibiotics. She could not move around much in hospital due to the pain after the epidural wore off. Dianne quietly described it *'as very uncomfortable because I couldn't move much'* (12.2 D35).

Vaginal Bypass: 'Off to theatre'

Those participants who experienced a caesarean section were frank in their descriptions of feeling afraid at different stages as different events and interventions unfolded during the theatre experience. For instance, participants described being scared as they were taken on a trolley to the operating theatre. Sarah reflected *'rolling down towards the theatre… lights flashing above your head and thinking 'oh my God, what are they going to do to me?''* (4.2 S58). Likewise, Lee-ann said she felt '*absolutely petrified'* but clarified the only thing she was scared about was the epidural, not the Caesarean itself (11.2 L18). Similarly Sarah described not feeling really worried about the caesarean itself, *'just more worried… he [baby] wasn't going to be alright'* (4.2 S59). She reasoned that *'if it required a caesarean to get him out, well that's what it is going to take'* (4.2 S59).

Sarah revealed, however, that she then began to feel physically afraid when she was put onto the *'little narrow operating table'* (4.2 S32). She expected the insertion of the

epidural to be painful and was concerned that she would not be able to keep still and that the anaesthetist would '*miss and do damage to [her] spine or something like that'* (4.2 S32). Being scared continued for Sarah after the epidural was inserted as she knew *'they're going to start cutting me now'* (4.2 S37). The assembly of the screen between her and the surgeons added a new dimension and heightened her anxiety. She did not want to see what they were doing, but wondered: *'Are they doing what they are supposed to be doing'?* Additional questions that pressed on her mind were: *'Are they going to muck something up or leave something in me? Are they going to get to him [her baby] in time'?* (4.2 S36).

Although her mind was anxious about the events unfolding in theatre, Sarah noted that after the insertion of the epidural she *'didn't feel anything else after that.'* Lee-ann added to this by saying that it was terrific to be alert through the procedure but the sensation of surgery with the epidural anaesthesia *'felt really bizarre'* (11.2 L25):

> *...All you could feel was pulling and prodding and you could feel your whole body sort of jerking around because of their pushing and prodding and then all of a sudden they go here's your baby and they pop her over the… screen in front of you* (11.2 L26).

Experience of First Meeting

Lee-ann related that when she looked up to see her baby for the first time *'I just started bawling my eyes out again'* (11.2 L27). In addition, Lee-ann stated that she felt *'ecstatic, I couldn't have been happier… '* (11.2 L27). Lee-ann reported that she did not get a chance to hold her baby straight away, but was happy that her baby could be cleaned up prior to her first hold. In recovery room Lee-ann *'felt a bit out of it'* but when she was taken back to the ward the first thing she said was *'I've got to hold my baby.'* She described feeling as 'proud as punch' (11.2 L39).

In contrast, Sarah recounted that although she was aware of the surgeons tugging as they performed the surgery, the sound of her baby's first cry seemed *'weird'* (4.2 S14).

She described it *'was like he was actually here'* (4.2 A14), like a dawning realisation, a first conscious awareness. Sarah noted she *'only really got a quick look at him.'* She was unable to hold him as she was positioned on the operating table with arms both extended: '*I was lying there like on a cross… and they were still stitching me'* (4.2 S14). Sadly, Sarah reported that she could not remember anything between hearing him cry for the first time and waking in recovery (4.2 S14). This is further described in the following chapter.

Synthesis: Birthing in a Technological Age

A number of medical interventions were experienced by this cohort of participants revealing the existential tenets of lived body and lived space (van Manen 1997). Induction of labour involved prostin gel or tape, with Syntocinon infusions also used to induce or augment labour if required. Foetal monitoring with a cardiotocograph (CTG) machine required women to be lying down or sitting and having straps encircling their abdomen. Anxiety and worry increased for some women as the audio signal of the foetal heart rate was heard to slow, or they observed the graphs of the contractions. Antenatally most women articulated concerns and fears about epidural anaesthesia but found it to provide great relief if they became exhausted or distressed with a prolonged labour. All women having an epidural progressed to an instrumental delivery. Most significantly the use of technology such as intravenous lines, CTG machines and epidurals were confining and irksome, and restricted movement and the use of comfort measures such as walking around, or use of showers. Participants having a caesarean birth experienced a myriad of concerns as they were prepared for surgery. They did not experience any pain during the surgical procedure but were aware of pushing and pulling and prodding and their whole body jerking around. Participants having caesarean births were not able to hold their baby until in recovery or arriving on the postnatal ward.

Conclusion

This chapter has explored participants' experiences of labour and childbirth. Key themes emerging from the insights were confusion and uncertainty about recognising

labour and the lived experience of uterine contractions and spontaneous rupture of the membranes. Participants used physical and psychological measures to manage the initial pain of labour and most progressed to utilise medical pain relief. Women were supported during labour by their partners and other family and friends as well as by midwives. Findings concerning the moment of birth centred on concentrated maternal effort in second stage, the experience of meeting their infant for the first time, a sense of achievement and the physical environment. The final section of the findings explored participant's experience of birthing in a technological age. The level of medical interventions among participants was striking and raises questions about the changing definition of what is considered normal and usual in maternity practice.

Women's experiences of induction and augmentation of labour via artificial rupture of membranes, Syntocinon infusion, foetal monitoring, and epidural anaesthesia, instrumental and caesarean delivery were all explored. The next chapter explores the findings concerning participants' experience of early motherhood in the postnatal period between birth and eight weeks.

Chapter 7

Postnatal: Awakening to a new world

Introduction

This chapter presents the insights of the study concerning women's experiences of early motherhood in the postnatal period. Women's accounts of labour and birth were explored in the preceding chapter and this chapter presents the next phase of women's experiences of early motherhood. Interviews were conducted around two weeks and eight weeks after participants gave birth to their infants. The insights relating to this period of early motherhood have been grouped around themes of living the physical experience of early motherhood, learning to feed, learning to mother and relationship changes.

Living the Physical Experience of Early Motherhood

The lived physical experience of early motherhood was explored in participants' accounts in this study. A number of factors influenced individual women's postnatal experiences, such as the duration of their labour, the nature of the birth of their baby, the presence of any complications in the birthing process, their experience of infant feeding and the level of support available to them through their relationships. The participants' physical experiences are discussed in detail.

'I've just had a baby'

The immediate postnatal experience described by participants varied. Rose had a spontaneous vaginal birth and an intact perineum. She related that in the postnatal period *'I felt quite good. Didn't really have any pain'* (5.2 R59). Similarly Bernadette shared: *'... straight away I was feeling really good physically… even with the stitches and stuff'* (9.2 B93). On the other hand, Gail depicts some of the magic of early motherhood she experienced *'I just sat there and just looked at her in amazement that 'oh my God, I've just had her' … 'just having her there you don't want to sleep in case you miss something or something happens' (laughs)* (7.2 G119-121).

In contrast, however almost all the other participants reported weakness, discomfort, or having limited movement in the immediate postpartum period. For instance, Kate shared that after the epidural wore off she felt *'very sore, I needed a few ice packs'* (10.2 K85-86). Christie was surprised not to be up and about the next day after having a spontaneous vaginal birth, but attributes it to having a third degree tear. She related:

> *I couldn't move at all. Like even to slide across the bed… it was like I didn't have my strength to push myself over* (6.3 C124-126).

A number of participants had an indwelling urinary catheter inserted, associated with having epidural anaesthesia during labour or a caesarean birth. The catheter was experienced as restrictive by several participants after the birth. For example, Jess said: '*I couldn't roll over coz I had the catheter on one side and so I could only roll over that side'* (3.2 J34). Likewise, Dianne was restricted in her movements in the immediate postnatal period due the complications with the birth of her baby as well as having an indwelling urinary catheter attached.

Xerri had a spontaneous vaginal delivery and was able to get up and about but related:

> *…The first few days I was having trouble sort of walking around because my blood pressure was low and I'd take a few steps and sort of feel like I've got to sit down. I felt pretty yuck... It felt like everything was in slow motion… I felt zonked for a good two days* (1.2 X55-58).

Jess had a spinal leak following an epidural anaesthesia during labour. She shared that she could only roll to one side as she had a urinary catheter and that *'Every time I lifted my head off that pillow I felt dizzy. And I couldn't hold her I just wanted to lay down. ... Every time I lifted my head this instant headache would come'* (3.2 J38-39). Interestingly Sarah was sore after having caesarean surgery, but related that her pain was not as much as she anticipated it would be (4.2 S26). In contrast, Lee-ann experienced several complications following her caesarean surgery. All she wanted to do the next day was get up and have a shower but related that she could not:

> *Jeffrey had to actually hold me… actually hug me to get me into the shower and it was like little baby steps … because of the pain [and] weakness. I mean I just couldn't feel my legs*

properly still. I was a little bit wobbly and I was doped up on pethidine because of the pain (11.2 L65-66).

'Hard to sit comfortably'

Of the participants who had a vaginal birth, only one had an intact perineum and reported no discomfort postpartum. The others all reported having sutures in their vagina or perineum to repair either a laceration or episiotomy. A second degree laceration or episiotomy involves skin and muscle and can vary from a small to more extensive tear (Chapman 2003: 299).

Almost all of the participants requiring sutures described their perineum and sutures as either *'very sore'* or *'very very painful'* afterwards and some noted they *'hurt like hell'* in the first few days (7.2 G61). One participant, Ursula, did not experience any discomfort when sitting following her perineal laceration. Ursula was initially told she had a few little tears that did not require any suturing; however her doctor was later called back to the hospital to suture two small lacerations in her vagina. Ursula was happy with this as she *'did not want to be cut'* referring to an episiotomy (8.2:U81).

For the remainder of the participants, there was a great deal of discomfort associated with childbirth. For example, Angela commented that after giving birth her *'vagina was killing (her')* and that she felt *'battered and bruised'* (2.2 A45-46). She described being puzzled when offered ice packs for her perineal stitches, but concluded the *'condoms with ice in them'* were *'heaven'*. Likewise, Xerri found that it was hard *'just trying to sit up to sit comfortably to feed … and going to the toilet'* (1.2 X60). She commented *'it was worse than trying to push [my baby] out.'* Xerri described a vivid word picture of her experience of sitting to feed:

> *I'd have like one pillow under this side and, you know sort of sit… it was awkward. I ended up with a sore back because I was trying to sit carefully to… not hurt myself. … it was hard. And I found if I was sitting for about 10 minutes I'd have to get up and sort of move positions or go from the bed to the chair… just to change the way I was sitting… or I just walked with her on the boob* (1.2 X62).

Likewise Jess reported being unable to sit down comfortably due to the pain in her perineum. For Jess the only way she could be comfortable was *'to sit down on [her] side'* (3.2 J57). This

discomfort for Jess continued for some time. When she went out to lunch a week after giving birth she could not sit on the chairs because of the perineal stitches (3.2 J183).

As healing occurred over time the participants with perineal tears or episiotomy wounds reported less discomfort. Angela noted for example, that while her perineum was initially very tender it had settled by the third or fourth day after birth, although it remained sore for a couple of weeks (2.2 A49). Gail said it took a good week before she felt comfortable going to the toilet (7.2 G78). Xerri noted that it was around day 12 before she could sit comfortably (1.2 X65). Not surprisingly, Xerri said being able to sit comfortably helped with her mood as she had been in pain just sitting and having to deal with a crying upset baby and sick husband *'was hard'* when she was in pain (1.2 X66).

Bernadette, however, was not bothered about the repair of her perineum. She was more engaged with watching her husband and newborn baby, and noted that the sutures did not cause her much concern afterwards. Bernadette did, however, describe her experience of having a shower the morning after the birth, initially feeling *'shell shocked'* (9.2 B95).

> *Can I be graphic? It was just scary because it didn't feel the same down there. I was like 'oh they've sewed me up' (laughs) and it was just all swollen and bruised and everything like that… I thought 'I'm really glad I don't have a mirror because if I looked at it I'd just go shit (laughs) what's happened?'… but... when I thought about it like ten minutes later I thought 'well it would be swollen and incredibly bruised' and considering all the stitches as well I just thought 'oh well' (9.2 B96).*

Bernadette reported at the two week interview that she felt *'back to normal'* (9.2 B93). However at the final interview she added that she was getting back to normal slowly. She related an incident where she ran across the road to the bank. She said: *'... just to run killed me. Everything flopped about… And it all just hurt. Like even internally it was like 'oh' it was quite jarring…'* When asked what was 'flopping' Bernadette explained: *'My boobs for one, my stomach for the other and it just felt all funny on the inside…'* (9.3 B48-50). Bernadette had begun walking and exercising again after her six week postnatal check-up when she was told everything was fine, but this incident at nine weeks after the birth suggested there was still some healing and recovery to take place.

Hayley spoke about her sutures and shared she was *'conscious of them very much all the time*' (13.3 H190). She commented that she had *'to be careful when I sit down and stuff like that'* (13.2 H75). Hayley described her perineum as feeling *'...almost like a muscle was tight. Like a cramp almost, but a constant one. Like if you'd sit the wrong way it would pull. You felt like it was going to pull apart'* (13.3 H58). Hayley had looked at the area after the sutures had dissolved but said she could not really see very much and could not see where they had been (13.3 H59).

Third Degree Tears

Three of the participants who had a vaginal birth experienced a third degree perineal tear. This is a laceration in the perineum that involves skin and muscle and extends to the anal sphincter (Chapman 2003:299). One participant, Kate described this as tearing 'all the way' (10.2 K54). For Kate, the birth of her baby was complicated by vacuum and forceps delivery and a postpartum haemorrhage. Kate related her experience: *'I lost a bit of blood so he stitched me up straight away and then I gave birth to the placenta and it burst the stitching and they had to do it again'* (10.2 K52). The pain from her sutures Kate described as *'like lots and lots of little knives stabbing you'*. Afterwards Kate checked the suture line and described it as looking *'like staples'* (10.2 K135-137.) Two weeks after giving birth Kate commented that her perineum was *'still quite tender'*. She revealed that *'it's gotten better. I don't quite walk like I've got a stick up my bum anymore.'* Kate explained that she still needed to sit on a donut ring cushion (10.2 K57-59). Later on Kate related that it was about three weeks after giving birth before she could sit on a soft surface such as a couch or pillow without her ring cushion, although walking was still slow. Kate felt that the pain from her stitches *'would never go away'*, and that it was only the around seven weeks after the birth that she had felt comfortable. At the eight week interview Kate commented *'it still pulls a bit occasionally', but she noted that* she *'didn't feel that kind of stinging (when she was) moving now'* (10.3 K103-112).

Similar responses were shared by Christie who experienced a third degree tear following a spontaneous vaginal delivery. Christie described the pain as *'a real tender stinging sort of sore'* (6.3 C106), noting that her stitches hurt *'almost to the point of tears'* (6.3 C108). As for the appearance, Christie described the sutures by offering the following analogy:

it was almost like… when something's stitched. Like… fabric and if you pull it tight… you can see the stitches going through but there's [sic] holes in between. … I was just really uncomfortable (6.3 C107).

Christie shared that initially it was painful *'just walking [to a chair], and to sit down was a big thing … I felt in my mind I had to [say] 'it's alright, you can walk' '* (6.3 C130-131). Christie was advised not to lift her baby or anything else in the first few days postpartum. She commented on the intense pressure felt '*down there'* in the perineal area even with just laughing or coughing or sneezing (6.3 C102). Christie still experienced significant pain at the time of her six week postnatal check, and her general practitioner advised it could probably take six to eight months for her trauma to heal (6.3 C99). At the eight week interview she did share that her perineum was *'feeling heaps better.'*

Another participant, Dianne experienced a traumatic forceps delivery in theatre and suffered considerable perineal trauma resulting in bruising and extensive suturing. Dianne shared that during the birth her baby had become stuck at the shoulders and *'that's why they cut me so much to get him out'* (12.2 D32). In addition, Dianne required two vaginal packs, a perineal drain tube and urinary catheter to manage her vaginal and perineal damage. She also had intravenous lines inserted to provide fluids and antibiotic coverage. Dianne shared that *'I felt like an alien with all these things attached to me'* (12.2 D155).

As a consequence of this, for Dianne the initial period after giving birth was *'surreal'*. Once the epidural anaesthesia wore off Dianne explained that she *'couldn't move around properly because of the pain'* and the presence of the *'catheter and… the drain where they had done the episiotomy.'* She continued to relate that *'.... it was very uncomfortable because I couldn't move much'* (12.2 D34-35).

Furthermore, Dianne was distressed to be told on the postnatal ward that the traumatic birth she had experienced would probably result in ongoing urinary and faecal incontinence. Dianne was left with the impression that she would need to wear nappies. She related her experience of that encounter with a midwife*: '... It's not really what you want to hear the second day you've had a baby and you're full of stitches and stuff'* (12.2: D195). She disclosed *'she really sort of scared me. That was pretty awful for her to do that because she was quite blunt…'* (12.2 D194). This information was later corrected when she was transferred back to her local maternity unit where it was explained to her that if she had any

incontinence problems that could not be fixed by exercise they could be managed by a procedure or by surgery. Dianne was upset that she was not given that information initially.

> *Whereas she didn't tell me anything like that so I was thinking I could be wearing a nappy for the rest of my life… Yeah and you're not wanting to hear something like that. After she left I just burst out crying 'I'm going to be wearing a nappy for the rest of my life' … I was so scared (12.2 D199-201).*

Three and a half weeks after the birth Dianne spoke about her perineum as still being

> *'sore. It hurts. I suppose it's like sitting on stitches… sitting on a heap of stitches. It's like … if you had stitches in your elbow and you're leaning on your elbow'* (12.2 D46).

Dianne though, expected that as it was a deep wound it would take a while to heal, especially as she is always sitting on it or moving around. She was also advised that her recovery would be like a caesarean and take six weeks before she '*came good'* which she saw as '*all right'* and acceptable (12.2 D110). Dianne had inspected the suture line and shared that *'it's all gone purpley-black now. That's good, that means it's healing I guess'* (12.2 D48). At this stage she described it as *'a dull pain … You can't walk very fast… I sort of shuffle more than stride. (laughs) You've got to be careful when you sit down…'* (12.2 D111). Dianne also commented that she *'couldn't imagine running or anything else at the moment* … (12.2 D210). At the final interview Dianne shared that her perineum was still *'a bit tender',* but not like it was. Dianne says she felt *'lucky'* to not have had any of the incontinence problems outlined by a midwife in the immediate postnatal period (12.2 D195).

These three participants' experiences were more extreme than the other women in the study. However they provide a picture of what some women confront and experience in the early days of motherhood. While the experience of perineal pain generally lasted from 12 days to three weeks for participants who had an episiotomy or second degree tear, the experience of perineal pain persisted longer for those with a third degree laceration. The three women who experienced third degree perineal tears generally reported that it took about six weeks to be able to sit comfortably to feed and that some pain was still present at the time of the final interview, some eight to eleven weeks after giving birth.

Vaginal Bypass

Two women, Lee-ann and Sarah had emergency Caesarean births. Lee-ann shared that after her Caesarean surgery her abdomen *'…was very sore'* (11.2 L93). She explained *…' the first few days …the very top part of the belly was sore… And then after that it was the bottom part of the belly that was very sore for quite some time'* (11.2 L98-99).

Lee-ann added that she '*…was on pethidine for the pain for about three or four days in hospital. And then it was just Panadeine and Panadol*' (11.2 L101). After discharge home from hospital she only took one dose of Panadol for pain (11.2 L102).

For Lee-ann, however, it was the other things linked with the Caesarean birth that were problematic for her, such as the associated intravenous infusions and urinary catheter. In addition it was *'very hard ... having someone else to do things for you'* (11.2 L87). Lee-ann explained some of these postoperative difficulties as follows:

> *...And your tummy's sore and she's hitting the needle further into your hand and banging it around and so forth. It's very hard. .... And I mean in that sense of things it was hard to deal with. Not being able to do everything yourself. Not being able to breastfeed yourself ... (11.2 L124-125).*

Despite this, later on at the eight week interview, Lee-ann reflected on her options for another pregnancy and concluded that: '*Definitely I'd be having another Caesar. Without a doubt. ... The Caesar was fine, yeah. No problem at all. It's just everything else afterwards'* (11.2 L198, L201). The *'everything else afterwards'* included the challenge of not being able to do much for six weeks. At the two week interview Lee-ann shared that:

> *... not being able to drive is absolutely driving me nuts ... being able to drive myself to doctors or up the shops to buy a loaf of bread or something, I think that's the main thing that's really bothering me…* (11.2:L90).

Sarah recollected that after the emergency Caesarean birth of her baby she was given *'a quick look'* at her baby immediately after he was born; she then vomited and has no further memory of events until she awoke in recovery.

The first time I got to hold him was when I was in recovery… And it was a bit weird because I was still out of it because of all the drugs. I'd woken up and there were people pushing me and prodding me, changing sheets underneath me and putting more hot towels on me and then I get this baby thrown in my face and I'm like, shit. Okay, obviously that's mine (laughs)... he didn't really cry at all he just was very asleep basically by the time I got to hold him… but I ended up falling asleep (4.2 S15).

Sarah related she was *'still out to it'* until about five hours after the birth of her baby. She awoke to having friends ring with congratulations but says *'I could barely speak to them on the phone… I think it was a mixture of pain killers and the fact that I hadn't slept that long …* (4.2 S17). Although Sarah described expecting huge pain, she commented that *I'm sore but not as sore as I thought I was going to be… I'm not saying it didn't hurt but I was able to get up and walk around the next day, very gingerly (laughing)...* '(4.2 S59).

Sarah commented that *'getting in and out of bed hurt'* but that she was given a range of pain killers: *' I had anything from morphine to Panadol available to me'*(4.2 S60-61). What complicated the situation for Sarah somewhat was that she had a cold when she went into labour so had difficulty trying to avoid coughing post operatively.

I spent most of the time trying not to cough. And even when I did that and pulled my knees up and got into a sort of foetal position, it still hurt so I chose not to cough (laughs). Which is actually quite hard (4.2 S60).

For these study participants the experience of having Caesarean births involved abdominal pain but the pain was not as severe as these women expected. Nevertheless, other issues associated with a caesarean birth presented difficulties and frustrations.

'There was all that blood'

Half of the participants in this study) experienced a postpartum haemorrhage (PPH). Postpartum haemorrhage is defined as bleeding occurring within 24 hours of childbirth measuring 500- 600ml or more (Fraser and Cooper, 2009). Two of these participants had caesarean deliveries of their babies; the other women had labours lasting 21 – 26 hours and instrumental deliveries. All except one of the six participants experiencing a postpartum haemorrhage had either an epidural analgesia or spinal block anaesthesia inserted during

labour or prior to their caesarean birth. Only one participant required a blood transfusion after haemorrhaging and all women were well enough to have their babies nursed at their bedsides. The experience of what bleeding was like for the participants is described in the following examples.

Ursula had an estimated blood loss of 600-700 ml after childbirth assisted by a ventouse vacuum extraction. She related: *'I was bleeding a fair bit when I was sitting down... they gave me Syntocinon but it hadn't gone through because… it [the intravenous drip] was dislodged a little bit… So I just kept bleeding and bleeding'* (8.2 74-75). Ursula recounted that *'It looked like a war scene, blood everywhere'* (8.2 U78).

Lee-ann related her experience of haemorrhaging after returning to the postnatal ward after an emergency caesarean birth:

> *I said that I was bleeding and my fiancé was there when [the midwife] checked me... And he was actually handing pads after pads after pads [sic] because I was just bleeding that much… I couldn't see what they were doing... I was still numb at that stage. But I was petrified by the look on his face. [He looked]… very serious and very concerned (11.2 L63-65).*

Following this, Lee-ann required two units of packed cells to replace her blood loss. She went on to have a secondary postpartum haemorrhage manifested by lower abdominal pain and further bleeding. An ultrasound scan revealed retained placental products in her uterus and she required a curette which was performed under general anaesthetic in theatre on the fourth day after her baby was born. Lee-ann disclosed: *'There was so much getting done to me. I couldn't really enjoy having this gorgeous little bundle'* (11.2:L150).

Later Lee-ann revealed that she did not realise the extent of the emergency until after she came home (11.2 L188). At that time her partner shared that he had been very stressed and worried. She relates that: *'He thought at one stage he was going to lose me… He was petrified he was going to get this gorgeous little baby and not have me* (11.2 L174).

My body has changed …

In the postnatal interviews women discussed their experiences of their body physically changing with the birth of their babies. Issues to be discussed around this theme include the physical changes following childbirth such as alterations in body shape, abdominal changes, being 'scared to go' to the toilet, and tiredness. Participants also described significant changes in their breasts after childbirth, but these will be discussed under the theme 'learning to feed'.

Study participants expressed pleasure at no longer being as physically large as they were late in their pregnancy. Christie noted: *'You feel like you can bend down' without having that 'big belly in the way'*. She described feeling less restricted than *'with having a baby inside you'* (6.2 C2). Likewise Rose said her body felt *'less weighed down'* and it was easier to walk around and not *'have to waddle'* (5.2 R105). In addition, several participants described finding it easier to sleep on their stomach. Bernadette summed up the experience of no longer being so physically large:

> *I just feel back to normal... I just felt really good just to not be large as I was. I was finding it really hard just to carry it around every day. So straight away… I reckon like within day three [sic] I was feeling really good physically* (9.2 B93).

Participants generally described their abdomens however as being *'floppy'*, *'floppier'* and having a *'lot of loose skin'*. Kate noted her abdomen *'kind of instantly went like a balloon'* (10.2 K133). Similarly Ursula noted that: *'there's loose skin and a bit of fat padding on my belly'* (8.3 U22). Gail described herself as having a *'jelly belly'* which wobbled as she moved, and being amazed that her baby fitted inside her (7.2 G84-86). Several of participants noted that their tummy *'kind of hangs over'* (10.3 K58). Sarah divulged that while she was almost back to normal that: *'I've got a pot belly now. There is a line… this little bulge that hangs over the line* (4.3 S14-16).

A number of participants were back to their pre-pregnant weight or below at the time of the final interview but noted that their shape had changed. Some were pleased to fit into their pre-pregnancy clothes, but others did not fit into their 'normal clothes'. Dianne's comments are reflective of the participants in stating: *'I'm back to my normal weight, it's just my body shape has changed a bit. Like my tummy sort of sticks out a bit more now'* (12.3:D27). Most women

planned to start walking more to reduce their post pregnancy weight. Some however, recounted that losing weight would be a bit of a struggle.

The presence of stretch marks was a reality experienced by a number of the participants. A few participants noted that they had stretch marks *'everywhere'*. Others shared that they had them on their hips, around to their bottom, and on their stomach below the belt line. Others had a few, but felt they were minimal. Some participants had them located under their breasts so they were not really noticeable. Dianne described hers as a *'purpley-reddy colour on her lower abdomen'* (12.2 D107) but commented that *'you've got to have some battle scars'* (12.2 D108).

'Scared to go …'

A number of participants had concerns about their bladder and bowels after giving birth. For instance, Angela disclosed that after the birth: *'Either way I sat on the toilet and had a wee it stung like all Hail Marys'* (2.2 A45). Angela experienced a second degree perineal tear as well as an anterior vaginal tear associated with her spontaneous vaginal birth. There was only one participant, Ursula who divulged experiencing some urinary incontinence in the postnatal period. At her interview (five weeks after the birth) Ursula related that while her perineum had never been uncomfortable: *'the battle I've got at the moment is the urge to go to the toilet and not quite making it* (8.2 U83). She related that she drinks a lot of water so *'it's like when it hits it hits'* (8.3 U84). At her 8 week interview Ursula was *'still having trouble with [her] bladder'* (8.3 U16). She had seen a physiotherapist but said she had been very busy and kept forgetting the exercises (8.3 U12). Interestingly, the three participants with third degree tears did not experience any trouble with urine leakage when coughing or sneezing.

Most participants were anxious and hesitant about using their bowels for the first time after having their baby. Bernadette shared; *'I was very worried about the first motion. But once it was passed it was all right'* (9.2 B96). Angela also disclosed:

> *…I was really worried about doing number two's for the first time… I was sitting there thinking 'Oh, I can't push down there again' (laughs). You have so much going on down that end (laughs) …that's the business end of the deal and yeah, it's all very tender* (2.2 A48-49).

Similarly Gail revealed that she *'was scared to go to the toilet'* because of the memory of pushing her baby through the birth canal. She explained that the pushing phase of labour *'felt like you are going to the toilet'* and the thought of the pain made her tense up and think *'this is going to hurt'* (7.2 G75-76). Gail shared that it took a week before she felt comfortable going to the toilet.

Angela however, related that using her bowels for the first time was not as bad as she thought it would be. Part of the concern several participants divulged was that they would sustain tears when using their bowels after having their baby. Kate shared: *'you just feel like you're going to tear... 'It didn't. It was very, very sore for a while*' (10.2 K65-66) *'... the first few times it was very uncomfortable'* (10.2 K70). Likewise Dianne described using her bowels for the first time as *'Relief that I could actually do it and nothing had split open'* (12.2 D202). She relates that it was not painful for her as she had been given a softener *'It was just relief that it was working okay and that yeah, I had no accidents or anything. ....Nice to know it was all working properly'* (12.2 D203). Each of the three participants with a third degree perineal laceration said at their final interview that they no longer any problems with their bowels, which were working normally. This could be attributed to the fact that these women are usually given softeners immediately after the birth.

Tiredness

The tiredness of being a new mother was described by participants as a different kind of tiredness to that experienced beforehand. Previously tiredness following a party could be managed with a 10 hour catch up sleep, however new mothers do not get the opportunity to have a long catch up sleep; they just have to keep going (2.2 A93). For instance, Ursula draws a picture of being exhausted as *'you just want to sleep but you can't because you've got a small baby'* (8.3 U121). She goes on to describe not being able to think clearly when in pain, and describes it as a *'continual kind of tiredness… that's probably why I can't concentrate'* (8.3 U122).

What made the situation worse for some participants was not being able to sleep while in hospital as they were alert to their baby's every noise, and thinking the baby would wake up any second (3.2 J54). On the other hand, a few participants described only being tired if their baby had a restless day. In contrast others described being initially totally exhausted for the first few weeks and finding it such an effort to get themselves out of bed, but having to get up

to feed the baby (8.3 U121). For some participants tiredness was experienced as having memory difficulties and *'a mushy brain'* with trouble remembering names and other details (10.2 K124). A few participants found the initial tiredness in the first weeks as overwhelming and *'horrible'*. Xerri thought *'I can't do this, this is just ridiculous. ... I felt like I was never going to get a good night's sleep – never...* '(1.2 X81-82). For Xerri, being really tired was manifested by losing her patience quickly, not being able to handle things as well, and feeling more easily stressed. She illustrated this with her own example of responding to her baby crying when she was extremely tired, compared to when she was not tired:

> *Instead of me going in there and going 'What is the bloody hell is wrong with you kid?' Instead of not knowing what to do, I go in there now and go 'Oh, what's the matter darling?' and I'll give her a cuddle and I feel so much calmer and she picks up on that straight away* (1.3 X32).

Managing the tiredness and exhaustion of new motherhood was addressed in a variety of ways. Some participants described adjusting to the lack of sleep. This was done sensibly by sleeping when the baby sleeps, having small naps throughout the day, and having their husbands or partners telling them to go to bed when they were grumpy. A number of participants had an afternoon *'catch up'* nap if they were tired, although a few just dozed off watching the television until woken up by the baby crying. For several weeks one exhausted participant went to bed at 6.30pm when her baby went down for her longest sleep of 6-7 hours (1.3 X66). Having a good sleep meant Xerri could cope with her baby's crying and manage a bad patch better (1.3 X31).

At the two week interview many participants described being up for feeds 2-3 times per night. However a few commented that they had the same amount of sleep or slightly more sleep with their new baby as they had when pregnant and were up and down at night and awake tossing and turning. This was perceived as positive. At eight weeks postpartum one participant reported that her baby woke only once at night and occasionally slept through the night. Some women reported that they began to feel less tired at 6-8 weeks as their baby slept better in the day or longer at night. However for many women *'lack of sleep [had] become a part of ... life'* (2.2 A93).

The insights concerning women' physical experiences of early motherhood have been presented. The next section of this chapter will explore the insights concerning women's experiences of learning to feed their baby.

Synthesis: Living the Physical Experience of Early Motherhood

The postnatal period disclosed the existential tenet of the lived body (van Manen 1997). While some participants felt physically well, many participants initially experienced weakness, fatigue, and limited movement due to perineal pain, caesarean wounds or a spinal headache. Perineal sutures were described as very painful, causing women to feel swollen and bruised. For participants with third degree tears the pain and discomfort was multiplied several fold and women initially had difficulty walking to a chair and compared the pain to having little knives stabbing them and involving intense perineal pressure with just laughing or coughing. Having an abdominal caesarean wound was generally not as painful as expected, however it was difficult to juggle attachments such as intravenous infusions and urinary catheters, and rely on other people to help with showering or breastfeeding. Almost half the study participants experienced a postpartum haemorrhage.

A number of physiological changes were experienced by women postpartum. All women described dramatic changes in the fullness of their breasts as the milk 'came in', and generally described their abdomen as floppier and having a lot of loose skin. However women felt less restricted and lighter than when they were pregnant and found it easier to sleep comfortably. The amount of purpley red stretch marks varied between participants and was seen by some women as the battle scars of pregnancy. Most participants described feeling anxious and hesitant about using their bowels for the first time after having their baby and some expressed concern about their perineum tearing or splitting open. Some women experienced intense stinging when voiding due to perineal trauma or anterior vaginal tears after a spontaneous vaginal birth. Physical tiredness affected almost all participants and was manifested as losing patience quickly, not being able to cope as well and feeling stressed. The tiredness of new motherhood was a continual kind of tiredness where responsibility for a small baby meant that although you want to sleep you can't sleep, which became a way of life.

The insights concerning women' physical experiences of early motherhood have been presented. The next section of this chapter will explore the insights concerning women's experiences of learning to feed their baby.

Learning to Feed

Learning to feed was a solid theme in women's experiences of early motherhood. At the two week postnatal interview the issue of infant feeding was discussed at length by all participants, signifying its importance in their experience of early motherhood at that stage. Overall the theme of learning to feed consumed a major amount of interview time, second only to the actual birth story.

All participants began breastfeeding and all infants were being breastfed when discharged home from hospital. Each woman experienced breastfeeding difficulties in the early days and weeks after the birth with seven breastfeeding at the final eight week interview. The sub themes around 'learning to feed' will be explored chronologically as revealed in the interviews. These were: contemplating learning to feed; the first feed, the physical experience of breastfeeding, 'so many things happening', making sense of conflicting advice, and support to breastfeed. After discharge from hospital themes associated with learning to feed in the early days at home were: the first night home, 'not knowing', 'I'm not going to be able to do this', 'not enough milk', and 'feeling guilty for being a bad mother'. At the final interview around 8 weeks after birth women described 'getting it together' after mostly overcoming or managing earlier difficulties.

Contemplating Learning to Feed

How do you learn to feed? Some women discussed infant feeding and learning to feed at the antenatal interview while others did not explore the issue of infant feeding until the postnatal interviews. All women were aware that breastfeeding was recommended as the best source of nutrition for infants. Some women however, reported that they felt that breastfeeding was pushed as being better for the baby. Angela commented:

> *This feeding thing kind of freaks me out a little bit. ... I just feel it's a lot of pressure. ...there's some people who just go on and on about it so much, even some midwives and you feel under pressure already… to do that. I'm not sure how I feel about it. I mean I'm going to give it a go because that's how I am as a person because I'll give anything a go a few times (2.1 A4).*

Gail found antenatal education helpful for providing information about a range of issues, including situations that she might not be aware of. The class Gail attended covered breastfeeding issues including managing the situation where a baby might not take to the breast.

> *I thought it was great. It was really good. They explained a lot. A lot of things that you don't think of ...like taking the baby home and if you have problems or… if you're breastfeeding and the baby won't take to you, how they work around it (7.1 G69-70).*

Angela also found the antenatal classes helpful and described her introduction to breastfeeding from that antenatal class. A key image she held from the breastfeeding information session was of her husband's discomfort at being the only man present at the class as they learnt about positioning to breastfeed. Angela noted

> *... the third week we turned up it was all about breastfeeding and my hubby was there and I was trying not to laugh because he obviously felt a bit out of it. Everyone was holding teddy bears up to their breasts and he was sort of sitting there twiddling his thumbs (laughs). But no, it was good. They're good, the antenatal classes. They pretty much cover everything, as much as you can do without actually experiencing it (2.1 A41).*

First Feed

During the postnatal interviews most participants recounted their experience of feeding their newborn infants for the first time. One quarter of the cohort described feeding their baby for the first time while they were still in the birthing room (in accordance with WHO policy), while another quarter related that they first fed their baby after they went to the postnatal ward. This specific issue was not discussed by the other women.

All of the participants who described their first feed found the experience to be positive. For instance, Bernadette related that her baby *'latched on straight after birth'* (9.2 B5) and fed in the birthing room. She shared *'I was really happy about that, that he was feeding ... so I was really relaxed'* (9.2 B64). Kate also fed her baby for the first time in the birthing room and offered the following:

[It was] wonderful and a little bit scary. You don't know quite what you're doing but you do know what you're doing and trying to feed- the midwives were a big help. Positioning... (laughs) (10.2.K103).

Angela similarly fed in the birthing room and shared a sense of wonder:

... It's amazing… I found I just felt protective of him straight away … So it was just him and I and the midwife and she was doing her paperwork and that was just a nice time to share because I felt like I hadn't sort of met him, you know. And um, I just got to have a good look at him … (2.2 A63, 65).

Sarah first fed her newborn in the postnatal ward after having an emergency Caesarean birth. As mentioned earlier, she was not able to hold her baby in the operating theatre after he was born as she was positioned on the operating table with both arms fully extended like on a cross. Sarah acknowledged that she was briefly shown her baby after he was born, after which she fell asleep or was sedated. The extract from her interview describes her experience around the time of her baby's birth.

The first time I got to hold him was when I was in recovery and mum and [the midwife's name] come back with him. And it was a bit weird because I was still out of it because of all the drugs. And then Mum sort of said to me 'Oh, do you want to breastfeed him?' and I thought 'Yeah, that will probably wake me up a bit' but I ended up falling asleep (4.2 S15).

Later in the postnatal ward Sarah described noticing that her baby was looking for a feed and she picked him up and put him to the breast herself. A midwife came into her room to check her and commented that the baby was not on correctly and showed her how to correctly position her baby.

Another participant, Xerri, realised about 7 hours after birth that her baby had not yet fed at the breast. She felt anxious as she tried to latch her baby on to feed in the postnatal ward and commented that:

She was finding it very hard to latch on to me and I was getting frustrated. I thought 'I'm not going to be able to breastfeed' and I started getting upset. I think the midwives kind of thought that my mum was going to help me with it. They didn't really come to me and say 'This is how things go'. They just sort of put me in the ward and left me… I mean they were

wonderful, they were all fantastic but I think they just thought we were a bit more in control than what we really were (1.2 X50).

Xerri's mum helped her to latch her baby in the postnatal ward. Despite this shaky start, Xerri said that her baby fed well after this.

Some initial breastfeeds were juggled around activities such as perineal suturing and visits from extended family or were delayed due to sedation following caesarean surgery. Women's experiences of breastfeeding their baby for the first time varied in terms of location and available support, but generally involved feelings of amazement and awe coupled with some anxiety and uncertainty.

The Physical Experience of Breastfeeding

All participants spoke about the dramatic physical changes experienced in their breasts when their milk 'came in' and were amazed by the increase in the size of their breasts. Dianne, for example reported: *'My boobs feel huge (l*aughs*'* (12.2 D23-24). In the same way Kate shared: *'I've gone from a B cup to a phew massive D [maternity bra], and I'm actually coming out of that'* (10.2 K142-145). She commented that her full swollen breasts were causing her some back ache as she was not used to it (10.2 K145). Likewise, when Gail's milk 'came in' she shared that her *'breasts got very sore'*. She described the increase in the size of her breasts when the milk came in as *'sort of instant'* and compared it to feeling like Dolly Parton. Her breasts felt *'heavy'* and she reflected that she woke up wondering *'Oh my God, where did they come from?'* (7.2 G79). Similarly Hayley discussed the changes in her body since her baby was born: '*the first thing was my boobs were as hard as rock (laughs). And that was very painful'* (13.2 H184). Hayley related that she noticed in the photos people were taking that her appearance looked different: '*When my milk started coming in they were really quite [big]… and I'm like 'oh my God!' (laughs). Like that doesn't look right' (13.2 H185).*

In addition to an increase in breast size associated with breastfeeding, participants also reported discomfort due to breast engorgement or nipple pain. Angela provided a vivid picture of the changes in her breasts in the first few days after giving birth:

…I had these great big engorged breasts, they were massive and they were excruciating, I couldn't even have so much as a sheet on them… they were... awful. They were just these great big, massive, hard, red, swollen [breasts]. So for me it wasn't the best… (2.2 A114).

Kate experienced nipple pain and explained: '*Yeah they were very, very, very sore for the first week. But, they would be. Not being used to being pulled on and sucked on (laughs)* (10.2 K107). Ursula had a lot of difficulty learning to attach her baby to the breast. She described the pain as like '*sandpaper at the nipples. …and also sharp a lot of the time too' (*2.2 U9). Several participants suffered from a thrush infection in their breasts. Ursula described it as a *'sharp pain going right through to my back. … razor like. Not much fun… actually I was crying every feed with her'* (8.2 U15). This was also experienced by Angela who depicted her severe nipple pain in this analogy: '*…it felt like [when] he was sucking, someone had a razor blade going up and down my breast slashing it every time he sucked. And my nipple was red raw and it was bleeding …* (2.2 A38).'

Learning to latch the baby to the breast was very challenging for all of the participants. Ursula recounted having a lot of help from the midwives to assist with latching her baby:

I couldn't get the positioning right [so] the midwives would grab her head and push her towards my boob and I'd be trying to get my boob in the right position and the nipple in the right position. …It was a lot of hands and in the end I think …oh I realised that I had to do it very gently and it still didn't work and I've got very sore nipples and lots of cracks… (8.2 U5-6).

Ursula assessed the difficulty as being her baby having a *'tiny little mouth not opening wide enough'* and also her baby being '*pretty determined'*. She related that:

When we were trying to force her on she wouldn't have a bar of it. I figured out in the end after about ten midwives that we just had to do it on her terms. Not tie her up,… she didn't like being … swaddled. She liked her hands free. If I put her near the boob if she resisted I'd just take her away let her relax. If she was crying let her relax, so calm down and then put her back on (8.2 U3).

This extract from the interview transcript revealed Ursula persevering through difficult feeds and the realisation that being gentle, helping her baby relax and following her baby's lead were a helpful approach.

Learning to feed was also affected by participants' physical experiences of early motherhood, as outlined in the previous section. The birthing experience and any complications such as prolonged labour, epidural anaesthesia, fatigue, postpartum haemorrhage or perineal trauma may influence women's experience of learning to breastfeed. For instance, Xerri shared that she found it difficult and uncomfortable to sit to breastfeed in the early days due to painful perineal stitches (1.2 X60). Each participant experienced breastfeeding difficulties in the early days and weeks after the birth.

All participants described difficulty latching their baby at the breast, having tender or grazed nipples and concerns about their milk supply. Hals of the participants experienced negative advice from family and friends. Other breastfeeding difficulties that were experienced included thrush infection, cracked and bleeding nipples and mastitis.

So Many Things Happening

In addition to participants' experiences of body changes and physical discomfort in the early motherhood period, for several of the women learning to feed was also complicated by the number of other things that were happening to them in the immediate postnatal period.

Angela, for instance, was sitting breastfeeding about three days after giving birth when she had some heavy bleeding. She described passing several blood clots the size of lemons. Angela commented that at the time this made her feel *'a bit frightened'* (2.2 A31). She continued to reflect that it was difficult managing the number of changes that occurred in a few days, which was overwhelming:

> *I was having trouble with breastfeeding and I had mastitis and I had thrush on my nipples and I was miserable anyway so. You know there are so many changes in so many days it can be quite overwhelming. Yeah, I found it to be really overwhelming* (2.2 A31).

Angela was relieved to still be in hospital and have the expertise of the midwives to monitor and manage her condition and help her breastfeed.

Two women had painful Caesarean wounds. For these women breastfeeding was initially experienced as difficult as it involved learning to attach the baby to the breast while balancing

a surgical abdominal incision, urinary catheter and intravenous line. One mother, Lee-ann, required a blood transfusion and had intravenous lines insitu for hydration and providing antibiotics, and another for transfusing blood. Lee-ann felt all tied up and had shooting pains in her hand where the lines were inserted as she attempted to manoeuvre her baby at the breast.

> *I had a bung on one side and a drip on the other …And the nurse that came in I asked her to give me a hand because I was worried about [baby] because of the bung… I was in that much pain with it and she kept saying, 'It's fine, it's fine' … 'You should be able to do everything perfectly fine and exactly the same even though you've got this drip coming out of your hand. And, you know, you're taped up to billy-oh so it won't move.' But it's a bit hard. It's a bit hard to be able to do everything and try to turn baby over… Especially when you've got inverted nipples and you have to wear a shield and you've got drips in hands and you've got scarring and sore belly and it's very hard* (11.2 L122-125).

This extract from the interview transcript captured Lee-ann's struggle to juggle the medical equipment she was connected to, manage inverted nipples and nipple shields, her caesarean wound, abdominal pain and learning to hold and feed her baby. On top of all of this, being told that she should be able to do this fine.

Learning to breastfeed does not occur in isolation. In addition to managing the challenges of physical body changes, recovery from childbirth or surgery and learning a new skill, study participants also entertained visitors and at times dealt with estranged family members. There were many issues, challenges and activities that intruded on women's experiences of learning to feed.

'Everyone says something different …'

Struggling to make sense of conflicting advice was a common theme related to breastfeeding in almost all the interviews. This appeared common to having babies generally, but was particularly linked with information about breastfeeding and learning to feed. Women consistently reported experiences of being told different approaches to take in breastfeeding their infants. For instance women reported being told initially to do something one way, and then finding that the midwife on the next shift would come and tell them that they were doing it wrong or incorrectly and to do it another way instead. This was followed by another

midwife advising that the previous information was incorrect and to do it another way again. In the community this would be continued with community based professionals such as MCH nurses and GPs also providing conflicting advice.

Two exemplars will be used to illustrate this point. Angela, was very articulate and animated as she commented on difficulties associated with learning to breastfeed, and in particular making sense of a cacophony of conflicting advice. This is illustrated by her comments:

> *... It's hard, you do find it difficult. Every one you talk to says something different, most times. Then you see someone else and they'll say 'Oh no, you shouldn't be doing it like that, you should be doing it like this'. And then you'll go to a doctor and he'll say 'I don't know who told you that but you should be doing it like this'. And you're like I don't know who's right. There is a lot of conflicting advice* (2.2 A94-95).

Angela related that in the hospital she closely followed professional advice. In the end the only way to progress, Angela found, was to listen to what was offered and determine what worked for her.

Gail also described the variety of advice available during the hospital stay. She detailed how she obtained a range of information and then outlined the decision making process she used to make sense of the different advice. Gail commented:

> *Every nurse or every midwife has their own way of doing things. And every time I asked something I made sure I asked three or four of them because they all had different ways and you sort of go 'okay this is the best way' or, one person might say she doesn't like that and you do it the way someone else says and she's happy... Just following each step of who says what and just trying it all and see which ones the best. Try it all (laughs) you've got nothing to lose. So you soon figure it out* (7.2 G5, G7).

Support to Breastfeed

Participants used several different sources of support in their journey of learning to feed; these included midwives, their mothers, their partners and sometimes other family members. Several participants were supported and assisted to breastfeed by their own mothers, including '*hands on'* support. Xerri laboured overnight and gave birth late morning. She described

realising that her baby had not been to the breast at seven hours of age and how her mum helped her latch her child to the breast in the ward.

> *... Being sort of still zonked and out of it from the whole thing I didn't really think, you know. And Mum said 'Oh it's 6 o'clock, what are we going to do? You know, you still haven't really got her on'. And in the end Mum just grabbed my boob and made a nipple and just shoved it in her gob. And ever since then she's been fine. So, and she latches on all right by herself now. So that's good. But it was just that first day I thought 'I'm not going to be able to do this'* (1.2 X51).

Jess was also assisted by her mother. Jess had a complication with her epidural and consequently had to lie flat for some days after her baby was born. Her mother stayed with her in hospital to look after Jess' baby as Jess was worried about not being able to get up to her baby. Jess' mother positioned the baby at the breast for her and helped her latch her baby as she lay flat on her back.

Angela described the first breastfeed with her son as a very positive experience, with her midwife clearing the labour ward to provide some quiet time and support for her first feed. With later feeds, however, she described finding different teaching strategies confusing and breastfeeding increasingly painful (2.2 A33). Angela also received support from both her father and her husband in helping her to breastfeed. Four days after her baby was born she was in agony with cracked and bleeding nipples, compounded by mastitis and breast thrush. Angela's mother had died some months before so her dad went to the local pharmacy on a Sunday to ask if there was anything that could help his daughter. He obtained information from a pharmacist and purchased nipple shields to take in to the hospital for Angela to try. Angela's husband Brett also supported her in breastfeeding their baby by being empathetic and consistently encouraging her efforts in persevering with breastfeeding. In addition their baby slept on Brett's side of their queen size bed, and he would get up to him whenever he woke for a feed, to comfort and settle him while trying to wake Angela to feed the baby.

In Bernadette's case her baby did latch on for the first feed straight after birth but after that she experienced significant difficulty in trying to latch her baby at the breast (9.2 B5). Bernadette described great support at the hospital from staff assisting her to attempt to breastfeed her baby. Each shift of midwives would spend a lot of time trying to help her latch her baby to feed. The following passage highlights her experience:

He wouldn't attach on, he wasn't suckling or something. So we tried nipple shields and everything and he wouldn't do it and we tried expressing and he would happily take that... but he'd only ever stay on for maybe a minute to two minutes and then cry and cry and cry. .... He'd just cry every time he'd suck, he'd just cry and cry and cry [in the hospital]... everyone tried to latch him on but he just wouldn't latch on for longer than two minutes (9.2 B3-6).

Unfortunately despite the best efforts of the hospital staff no one was able to assist Bernadette to latch her baby to breastfeed. Her baby cried a lot and it was presumed that he had some cerebral irritation following the delivery. Hospital staff gave him a dummy to help settle him and then commenced feeding Bernadette's expressed milk via a bottle and teat. Bernadette was discharged home from hospital expressing her milk and feeding her baby expressed milk via a feeding bottle and teat, supplemented with infant formula. While Bernadette was very happy with the support she received in hospital there were not any plans made for ongoing support or management of her breastfeeding difficulties after discharge from hospital. She was not referred to a lactation clinic or lactation consultant at any stage and used a manual hand pump to try and establish her milk supply.

These vignettes illustrate different types of support participants experienced in learning to breastfeed. Next the experience of learning to feed in the early days at home will be explored.

Early Days at Home

The first night home

All participants were breastfeeding or giving expressed milk to their babies when they were discharged from hospital. Taking their babies home from hospital was found to be challenging by all of the mothers. One or two families however, were surprised to find it easier than anticipated. Bernadette shared her experience of the first night at home.

... I was really anxious about coming home because he'd screamed the whole time [in hospital] and I was thinking 'oh what am I doing?' and I thought 'no, no, I need to do it'. And because Dave was there too I knew it would be okay. But we were anxious and the first night we were waiting for him to start screaming and we were sitting there and sitting

there going 'oh he's been four hours. Maybe we should wake him up' (laughs). We woke him up and fed him and he went straight back to sleep and... (laughs). So we slept… he slept, we had six hours sleep the first night. …And the second day we were like 'this is the easiest job we've ever had' (2.2 B75).

In contrast, for several other women the first night home actually was a nightmare. Rose described deciding to go home from hospital as she felt she had learnt all she could from the midwives. She then provided a graphic picture of her husband and herself sitting up at midnight with a crying baby. They were concerned about Rose's milk supply and did not know how to settle their baby:

... the first night was a nightmare… she just constantly wanted to be on the breast ... and awake and I don't think she was getting enough. So she was still awake all the time and James and I were sitting and I think it was midnight and we were both sitting on the couch like zombies just looking at each other thinking 'What the hell do we do?' (laughs) (5.2 R73).

For Xerri the first night home was also very difficult. Her milk had just come in, her husband was sick, and her baby had been screaming for ages. Xerri had read widely about pregnancy and birth, but had thought that breast milk was present from the moment of birth. Her baby was very unsettled and distressed and she felt overwhelmed:

I rang mum at 4.30 in the morning and 'I can't settle this baby down I don't know what's wrong with her.' Mum came round and she said 'Right, go and jump in the bath. Have a good cry, and go have a Milo and get in to bed'. So that was a help; that was really good. … I went in and turned the fan on so no one could hear me and just howled, just balled my eyes out for half an hour and it felt better (1.2 X6).

While the first night home went smoothly for a few participants, others were distressed and overwhelmed by feeding and settling issues. Next the problem of 'not enough milk' will be considered.

Not enough milk

Three of the women weaned their infants in the first three weeks after birth. Christie and Gail described having unsettled babies and perceived low milk supply. Their infants woke frequently for breastfeeds and were hard to settle. In Christie's case her baby had lost over 10 per cent of its birth weight while in hospital and she had been instructed about the importance of monitoring her baby's weight and feeding her baby three hourly. Christie was up and down the first night *'non-stop'*; as it would take nearly three hours to breastfeed her baby and get her settled (6.3 C50).

> *... So I didn't really get any sleep at all that first night. And I thought 'Well she hasn't really had anything and even if she has she hadn't done one of those really suckle on suck, suck drinks. And she'd lost so much weight...' so that next morning I thought 'She's just got to get something in to her. We'll go get some formula'. So we did that. But then I got a breast pump and I was expressing so I could see exactly what was going into a bottle and she was having some of me and some of formula but then I was expressing and there was no milk coming out. I just didn't have the milk. So then I've just gone straight to formula, yeah* (6.3 C50).

Christie revealed that *'I was nearly beside myself because I thought 'oh the poor little thing'... I was more concerned with the weight that she had lost... I just was worried sick with her'* (6.3 C51). When probed she disclosed that she was worried that *'if she doesn't drink something well she could die or something. Not die, but you know, it's important that she has to drink'* (6.3 C51-52). Christie weaned as she felt her baby was unsettled and not feeding properly at the breast. She also evaluated her supply by the amount of milk she could express. Christie was genuinely anxious and frightened about feeding and looking after her newborn baby. When she used infant formula she could see what her baby was taking in.

Gail's baby was also crying and unsettled during the first days she was at home. She thought some spicy food she had eaten may have caused her baby to be unsettled, but her baby remained grizzly over several days. Gail vividly described the series of events that ended with her using formula.

> *... I had a bit of trouble breastfeeding. I did it for four days and then on the Sunday she was really bad. Crying. Saturday night it started and Sunday she was all day the same. ...I*

thought maybe the [Taco] sauce [was a] bit spicy for her and it had gone through to her. And then come Monday… She was crying and I was feeding her and she was, I dunno, just grizzled the whole time... I tried putting her in bed with us and she'd sleep for a couple of hours then she'd be up again. So on Monday morning I rang one of the midwives and they said try expressing. Maybe she's not getting enough. And I got a friend to drop off the expresser Monday night and she wasn't getting close to enough. So I got Bob [husband] on Monday to bring home some formula and I fed her on the formula on Monday night because I thought she'd gone a day and a half without food, like without enough. And then on Tuesday I expressed and did the formula. Wednesday I just couldn't express anything. Nothing at all so we decided we'd just forget about that and just do formula (7.2 G12-15).

Like Christie, Gail could only express a small amount of milk initially and then that stopped. Both participants used breast pumps for the first time alone and when they could not express milk believed that this confirmed their milk supply was low or had stopped. This may have been different if they were supported and shown how to express milk and elicit the letdown reflex.

The third woman who weaned her baby stopped expressing milk when he was three weeks old after having been expressing since birth. Bernadette's baby never really latched on to feed for more than two minutes, apart from an initial feed just after birth and a single 10 minute suckle after discharge from hospital. This was despite numerous midwives helping Bernadette in her attempts to feed in hospital. Bernadette battled to establish her supply of breast milk. A prolonged labour, traumatic delivery, failure to latch the baby at the breast, exhaustion, and stress complicated her attempts to establish her supply. The introduction of a pacifier, infant feeding bottle and teat, and infant formula may have also compromised establishing a milk supply. Bernadette had used Maxolon medication to boost her supply while in hospital and was referred by the hospital to her GP after discharge from hospital for a further prescription of this medication as a galactologue. However Bernadette's GP was not familiar with the use of this medication for this purpose and declined to prescribe it.

There was not any planning or coordination of care to support Bernadette in her attempts to establish her baby on the breast or to maintain her supply after discharge from hospital. Both the hospital midwives and local MCH nurse failed to refer Bernadette to a lactation clinic or a lactation consultant. She was extremely disappointed to not be able to breastfeed her son. Not

having enough breast milk or perceiving that they did not have enough was distressing for participants. This was intimately linked with feeling they were not able to breastfeed.

'I'm not going to be able to do this'

Each participant felt at some stage that the challenges of early motherhood and learning to feed were overwhelming and that they would not be able to manage it. This is illustrated by Angela. She was in hospital, had cracked nipples, and felt that if breastfeeding involved the frequent feeds her baby had overnight then she did not think she would be able to do it:

> *... like at some stage you think 'this is too hard, I can't look after a newborn baby.' And he was on me every hour one night from midnight til six in the morning, and I was beside myself. And I thought if this is what breastfeeding is like I can't do this, in real life when you've got housework and you know, you've got yourself to look after as well. He can't be on me every hour and one of the midwives said to me 'Oh that's how it is sometimes' and I thought 'Rubbish, it can't be like that'* (2.2 A35).

Likewise Gail spoke about her concerns about not being able to breastfeed and the thought processes that were going on in her head. From this she extrapolated to other situations. Gail reflected that if she was not able to manage breastfeeding then how would she be able to manage other mothering situations, such as knowing if there was something wrong? It was frightening.

> *... And I suppose that's where it was hard with the breastfeeding... Because you sit there and think 'I can't do this and I can't do that'. 'How am I going to know if something's wrong or if I do something wrong?'...* (7.2 G109-110).

During the early motherhood period the demands of being a mother and learning to breastfeed were seen at times as too arduous and something that new mothers felt they could not achieve. This often became entwined with feeling guilty, discussed next.

'I blame myself …'

Participants often mentioned the idea of feeling guilty and things they felt guilty about. The concept of feeling guilty about being a bad mother was particularly strong in the area of infant

feeding and in relation to breastfeeding in particular. Women felt guilty for instance, if they decided to stop breastfeeding. However there was also a surprising amount of emotion present about not knowing or not understanding aspects of breastfeeding. This was expressed in terms of not knowing when the milk came in, not knowing if the baby was getting enough milk, thinking the baby was crying because he or she was not getting enough, and even starving the baby

Angela was one that spoke about feeling like a bad mother. Her baby went about two weeks without a bowel action and she did not know that can be normal for a breastfed baby. She related: *'I found it personally really quite difficult… I didn't know that, no one said that to me. So when he'd gone a week I was thinking 'Oh I'm the worst mother in the world''* (2.2 A109). The interview explored the issue of mothers' feeling responsible when anything happens with the baby. Angela shared her perspective: *'Because I'm feeding him, so obviously, maybe I'm not giving him enough, maybe I'm not adequate enough for him. You know what I mean? Like you just doubt yourself, sort of thing'* (2.2 A110).

Similarly Bernadette experienced great sorrow at not being able to breastfeed her baby or provide breast milk for her baby. She battled significant attachment and supply issues but reluctantly still ended up having to feed her son infant formula. The second interview with Bernadette took place about three weeks after she gave birth, just after she had unwillingly weaned. She spent a considerable amount of the interview recounting, scrutinising and reflecting on everything that she had tried in her attempts to initiate breastfeeding. After failing to attach her baby to the breast for feeds, she progressed to having her lactation also fail. She described the grief and loss she experienced in not being able to breastfeed her son or produce breast milk for him as devastating. She disclosed: '*When I started [to] have lactation problems I was just devastated. I was really sensitive'* (9.3 B88). Bernadette said she cried every time she fed him infant formula for days and days. She expressed some black humour and referred to the formula as poison, although her husband pragmatically told her that the infant formula could not be that bad. At the final interview when her baby was about eight weeks old Bernadette admitted that she still cried sometimes with the grief at not being able to breastfeed. At this time the grief had eased a little and the tears were less often but she still carried the pain and deep disappointment. Bernadette reflected: *'[breastfeeding] was the most important thing. Other than a healthy baby of course. It was really, really important and I'm still beating myself up about it'* (9.2 B24).

Gail also weaned a few days after discharge from hospital following perceived insufficient milk supply. Her baby daughter was very unsettled in the first few days at home and Gail thought she had been unwittingly starving her. She described the guilt she felt:

> *... it took a lot for me to deal with the fact that I let her starve for a day and a half. I kind of blame myself because being a mum you should know and all that and that made it hard. That made it really hard. Just without having the food I thought 'Oh what have I done to her?'* (7.2 G15). …I *should have known whether my breasts were filling up or not. They weren't filling up to feed her ...* (7.2 G19).

Gail blamed herself and she felt she had let both her baby and her husband down. Feelings of guilt and self-blame were particularly associated with infant feeding and contributed to learning to feed being difficult.

'It was the hardest thing'

Most of the women interviewed reported breastfeeding to be very hard, harder than expected. Angela described the issues that she had encountered and why it was hard:

> *Oh, he wanted to be held all day basically.... there were a couple of days a week where he fed almost constantly. And they're not like two minute feeds, he feeds for like twenty or thirty minutes at a time. So it takes up a fair whack of your day if he's feeding every hour, hour and a half... I knew it would be hard but I just didn't realise how hard... I didn't realise it would be so time consuming and then having to give him a bath, getting him dressed, change his bum…* (2.2 A78-86).

Gail similarly found being a mother and learning to feed hard. However the issue for Gail was that she felt it was up to her to know all about the feeding. She went on to explain:

> *I reckon that was the hardest thing mentally to deal with because it all revolved around me I suppose… it was up to me to know. And it was up to me to feed her…* (7.2 G113).

Other mothers were also surprised by how difficult breastfeeding was for them. Rose commented that she thought breastfeeding would be easy. She was quite shocked that it was as hard as it was.

... I thought breastfeeding would be an easy thing for me and for it not to be it was a bit of a shock... I think for me that was an emotional thing as well (5.2 R92-93).

Breastfeeding was experienced by many participants as harder than expected. Factors such as the frequency of feeds, the myriad of other baby care tasks, the burden of responsibility and the emotional aspect of breastfeeding impacted on this. The next theme explores how participants progressed in working it out.

Getting it Together

At the final interview, around eight weeks after birth almost all mothers were settled in a method of feeding their babies. Although all participants began breastfeeding, by eight weeks five had weaned their babies and were established with feeding infant formula. The most common reasons given by women for weaning centred on the perception of insufficient milk. Another participant, Bernadette, had attachment difficulties and lactation failure, while the fifth participant, Rose, described attachment issues and finding it too difficult to manage expressing milk and bottle feeding once her husband was back at work. It would take 30-45 minutes each time just to express her milk, and she would still have to feed her baby. Rose said she felt more 'free' when she stopped expressing and changed her baby to infant formula.

Those that were continuing with breastfeeding at the 8 week final interview were not necessarily free of problems, but they were, nevertheless, comfortable continuing at that stage. These women believed breastmilk was the best for the baby, they were gaining more confidence, they had help to refine attachment strategies, their sore nipples had resolved, or they were physically comfortable breastfeeding. The following examples illustrate these perspectives.

For instance, Angela experienced a number of difficulties with breastfeeding however she said that she stuck at it as she thought *'it was the best thing for [her] baby* (2.2 A44). She acknowledged that it was still difficult and that she gave her baby formula at night to top him up and help him settle for the night. At the eight week interview Angela commented that she felt each week was getting better. She mused however, about whether it was her baby getting better or whether she was getting more confident (2.3 A94).

Ursula was very keen to breast feed her daughter despite prolonged difficulties in learning how to latch her baby on to feed. She had very sore traumatised nipples for several weeks following difficulty in attaching her baby to the breast. Her sister actually taught her how to correctly position her baby at the breast, about six weeks after birth. Ursula also developed a chronic thrush infection in her nipples and breast ducts which made her experience of breastfeeding very daunting and painful.

Kate also experienced initial nipple soreness but she continued on with breastfeeding. At the eight week interview Kate described breastfeeding as much better (10.3 K110). The challenge for Kate was getting up for feeds in the middle of the night. Once she is out of bed and settled into a feed she describes the experience of breastfeeding her baby as *'pretty good'* (10.2 K111).

Synthesis: Learning to Feed

Learning to breastfeed was harder than women anticipated and all participants described some initial difficulties. The women's particular birth experiences and associated complications and interventions sometimes compounded the difficulty of learning to breastfeed. The existential tenants of lived body, lived space and lived other (van Manen 1997) were explored here. Usually the first feed occurred in the labour ward supported by the midwife, but for some participants it was delayed until after transfer to the postnatal ward. Women experienced nipple pain to different degrees which was described as tender or very very sore. Coping with intravenous lines, urinary catheters, blood transfusions, surgical incisions, painful perineal sutures or passing large blood clots was sometimes overwhelming as women concurrently entertained visitors, manoeuvred a crying baby at their breast and learnt to breastfeed. Often women also struggled with conflicting advice. Support to breastfeed varied with some women experiencing extensive help and a few describing intrusive rough intervention. In several situations family members such as mothers, sisters and husbands were significant source of support for new mothers.

The first night home was a nightmare for some, with the baby constantly feeding, awake, unsettled or colicky and exhausted confused parents unsure of what to do next. Having a crying baby that couldn't be settled and only slept a few hours at a time was erroneously interpreted as not getting enough breast milk. Being unable to express milk with a breast

pump used for the first time was often falsely thought to confirm the incorrect perception of low supply. For some, breastfeeding was seen as being too hard, especially if women became overwhelmed by disturbed nights, frequent feeds and lack of time to look after themselves. Women described feeling guilty if their lactation failed or they decided to stop breastfeeding and expressed self-reproach about being a new mother and not knowing or understanding an aspect of breastfeeding. At the eight week interview participants had all settled in a method of feeding, although a few battled some ongoing lactation difficulties. Those who had weaned spoke of greater freedom and an end to leaking breasts and cumbersome breast pads.

The insights reported in this section explored the theme of learning to feed. The next section will present the insights concerning the theme 'learning to mother'

Learning to Mother

Learning to become a mother was a strong theme in women's experiences of early motherhood. How does one learn to mother? All women discussed their experience of being pregnant during their antenatal interview. During this time however many women indicated that they did not really feel like a 'proper' mother yet. Becoming a mother was generally seen as something that would follow the birth of their child. This section will explore the theme of learning to mother as shared by women participating in this study. There were several aspects that made up the theme of learning to mother. Insights to be explored concerning learning to mother include: the emotional experience of learning to mother, the experience of not knowing, living with crying, motherhood being a lot harder than expected and integrating the baby into one's life.

The Emotional Experience of Learning to Mother

In the early weeks after the birth most participants described a continuing *'roller coaster of emotions.'* Jess, for instance, suffered a spinal headache after the birth of her baby and felt *'like [she] was being a bad mum'* (3.1 J46) as she could not enjoy her baby like she wanted to. Jess described her emotions after the birth as *'shocking'* (3.1 J113). Jess went on to explain that she had the '*baby blues'* on the third day after giving birth and described her emotional state:

Yeah, bawled my eyes out all day (laughs). I'd wake up and just look at her, [then] bawl my eyes out (laughs). As soon as somebody walked in the door to see me I'd cry again, shocking (laughing) (3.1 J114).

Jess reflected that she continued crying from this day until she was discharged another three days later. She added that at the time *'I just felt like I was rejecting her'* (3.1 J119). Jess' mum supported and encouraged Jess through this turmoil of early motherhood emotions. At the last interview Jess enjoyed sitting her baby on her knee and just gazing at her face and '*loves giving her cuddles'* (3.1 J82).

Most of the other participants were overwhelmed by the experience of giving birth to their child, to varying degrees. They reported just watching and studying their baby in wonderment, and some spoke about crying tears of joy. For instance, Gail described in the early weeks of being at home:

...a lot of days I just sat there and just looked at her and held her and just cried… you feel like you're on top of the world... I just sit there and think 'wow'. I watch her sleep... I just sit there and just watch her (laughs). I watch her for hours (7.2 G99).

Participants also recounted intense emotions as they tried to adjust to physical exhaustion and caring for an unsettled baby. Many participants were used to having a routine and patterns and experienced the early days at home with their baby as very gruelling. Xerri disclosed that *'the first week was very difficult at home'* (1.2 X1). She articulated her experience of distress and fluctuating emotions:

I found that my emotions [were] up and down all over the place. I didn't think I was going to cope; I was thinking 'I'm going to be one of these people who get this post-natal depression…' One minute I'd be crying then I'd be happy, then screaming and… I was a mess (1.2 X1).

In one example, Xerri could not settle her baby down the first night she was home and did not know what was wrong. Her husband was ill and unable to assist so she telephoned her mother who came around to her house in the early hours of the morning to help. Her mother settled her baby while Xerri had a bath and a good cry. Xerri described her emotions:

I was kind of overwhelmed. I felt like I couldn't cope with it all. I thought this is all too much, I just don't know what I'm doing. And why have we done this? ...it was hard (1.2 X7).

Other participants reported crying from exhaustion about the 'hardness' of being a mother. A number of the women thought the hormonal changes involved in lactation, lack of sleep and taking on a new role were factors involved in their emotional state. Rose described being really emotional in the early days after the birth and sums this idea up: *'it was just really emotional and on top of sleep deprivation and everything I was just crying and looking at this baby and [thinking] what do I do with it?'* (5.2 R91).

Many women in this study spoke about feeling overwhelmed and quite emotionally depleted at the end of a day, and how they would be encouraged and reassured by their partner. Gail's comments illustrated this situation:

... by the time Bob comes home of a night like my emotions are down. And I'm feeling crap and I'm not a good mum and I can't do it. And then he sits there and…. Like he reassures you, and I think 'Oh okay, okay'. You sort of start to boost yourself back up. You're ready for the next fall (7.2 G112).

Learning to mother is an intense emotional experience but is characterised by resilience. The next aspect of learning to mother to be explored is that of 'not knowing'.

Not Knowing

'Not knowing' is a theme that runs across the whole experience of learning to mother. Antenatally participants reported that they felt antenatal classes had covered the range of things they wanted to learn about, with hospitals indicating that parent craft skills would be taught during the postnatal hospital stay. After giving birth, however, a number of women in the study said that they felt it did not matter what you read or learnt about antenatally nothing could really prepare one for labour and childbirth.

Learning to mother involved many situations where participants did not really know what to do. Lack of knowledge was compromised further by uncertainty and confusion. The first days at home were difficult for most of the participants. Rose reflected on her first night at home and described it as *'a nightmare'* (5.2 R73). The first few days involved a lot of learning, according to the participants. For instance, Rose and her husband struggled through a maze of questions concerning looking after their newborn baby: *'The first couple of days was like what do we do? (laughs). When do we know when to change it? feed it? and all that sort of stuff?'* (5.2 R65). Rose described learning to mother as *'a whole new world'* as she read about sleep and settling techniques, expressing and storing breast milk and learning to identify her baby's cries.

For some mothers *'not knowing'* about something that was linked with caring for their baby was very difficult to deal with. They reported they had high expectations of themselves and felt that as mothers they should know how to care for their child. For example: *'being a mum you think instantly you should know. It should just come to you but it doesn't'* (7.2 G17). '*Not knowing'* was hard. Several participants related that they had been told by friends and family that one learns about mothering over time, which these participants anticipated would occur. However, paradoxically they still expected themselves to have knowledge about matters they had not experienced before, while at the same time articulating that this was a big expectation. This is encapsulated by Gail:

> *Everyone keeps saying 'oh you'll learn, you'll learn' and you do. That's what it's all about, but I just sit there and I think 'I should have known that.' And even Bob said 'well how would you know, you haven't done this before,' and I'm like 'yeah I know'* (7.2 G 18).

The issue of learning to mother and 'not knowing' became problematic when women's confidence was shattered by difficulties encountered. This situation is illustrated by Gail's story where her confidence was challenged in the first week by feeding issues. As she met problems with breast milk supply and then formula feeding she began to seriously doubt her ability to discern if something was wrong with her child or if she was doing something wrong. She noted:

> *... Between the breastfeeding and starting her on formula and over-packing the formula and all that it was a huge week. Because you sit there and think 'I can't do this and I can't*

do that'. 'How am I going to know if something's wrong or if I do something wrong' (7.2 G110).

Not knowing was a feature of learning to mother that participants grappled with during early motherhood. Part of this not knowing was the unexplained infant crying, which is discussed next.

Living with Crying

Managing infant crying and living with crying were closely intertwined with women's emotions and also the quandary of 'not knowing' what was wrong with the baby. Many of the women reported in the early postnatal interview that they felt very distressed themselves when their baby cried. Participants commented that they found it wrenched their hearts to hear their baby cry, and found it very difficult to listen to. Xerri shared:

I was unsettled by it. 'Coz she tends to know if I'm upset and she was very hard to settle down then. Umm.. but yeah, it made me feel… it made me feel sad. It sort of broke my heart to see her crying and… yeah I felt like I couldn't do anything right. …or that I couldn't get anything right to settle her down. …it was very, very hard. I didn't think I was going to get through it, put it that way. I couldn't even handle hearing her cry at the start … (1.2 X1).

In the first week or two after birth most women used a checklist strategy to address infant crying. They would methodically exclude or mange common reasons for crying such as tiredness, wet nappy, hunger, too hot or cold and so on. Gail details her approach in the following excerpt which illustrates the complexity of her lived experience as she learnt to mother:

Well I've got a little routine going. When she wakes up I change her nappy, I'll nurse her and sometimes if she's just tired she'll go back to sleep. Other times she'll still scream and carry on so okay she's up for a feed in ten minutes, fifteen minutes so I'll feed her and burp her, then normally she goes back to sleep. So if that doesn't work then I'll think okay she's just, like now, overtired and just wants a cuddle and to go to sleep so I just let her do that. If none of them [sic] work then I'm in trouble (laughs). So far they're working (7.2 G11).

Living with infant crying became gradually easier for the participants in this study, particularly as they became more skilled at deciphering and interpreting their baby's different cries. After a few weeks most participants could identify several of their baby's different cries; indicating situations such as hunger, wet nappy, tiredness or pain. As these women learnt to distinguish their baby's cries they were able to respond more appropriately to their baby's communications and needs.

The experience of living with persistent crying however continued to be disturbing and worrying to these new mothers in the first few weeks at home. This is illustrated by Xerri's account where she expressed that she *'felt sort of hopeless or helpless'* when she could not do anything to help her baby or settle her baby down (1.2 X103). On this occasion Xerri said she tried '*everything*'. Xerri provided a thick description of her experience of living with crying and learning to mother as she struggled to settle her baby (1.2 X 104):

> *I mean there are times like yesterday when she wasn't well ... and me being tired too I think doesn't help. I couldn't do anything to help her and I couldn't settle her down ...I mean I tried everything ... We'd taken her for a walk; we put her in the car. I was feeding her like nearly every hour and a half or hour to two hours just to try and keep her quiet and ... I bathed her. I tried massage. I tried everything and nothing settled her down. And she was screaming like blood curdling screams. And I thought 'There's something wrong'. ...I didn't know what else to do* (1.2 X103-104).

Xerri and her husband were quite concerned about their baby and took her to the casualty department of the local hospital to have her examined by a doctor. They were reassured that there did not seem to be anything wrong with their baby and were told to take her home and see what they could do. Xerri mused that she did not think they would be able to settle her down but noted that she fell asleep in the car on the way home from hospital. Xerri reflected that her baby was '*just overtired'*. This same scenario was played out by another participant who also sought emergency department assistance for unexplained crying in her baby. Several other participants used the 24 hour Maternal and Child Health Help Line for advice about infant crying. Living with and managing infant crying was stressful and draining for most of the participants interviewed and was a significant component of learning to mother.

‘I knew it would be hard, but I didn’t expect it to be this hard.’

The reality of early motherhood struck women in the early days after giving birth. All participants expected motherhood to be difficult in the early days but most were quite overwhelmed by just how difficult early motherhood was. Gail captured some of the wearying and tedious aspects of learning to care for her baby.

> *... and when you sit there and think ‘okay she’s got wind’ and you sit there for half an hour and she burps and everything else and you put her down and she spews and you think ‘oh God, I sat there for that long’. And she has great timing for doing it. Great timing. Like you’re changing her nappy and then she wets again…* (7.2 G116).

Gail reflected on this and contemplated that this tedium and frustration is another layer in addition to feeling emotionally ‘down’ and lacking sleep. She articulated the realisation that ‘*…this is my job and my responsibility and something I have to do… I’ve got to learn this and no point being miserable because it’s not going to solve it’* (7.2 G116).

In addition, most mothers were surprised how much time caring for one small baby would involve. Xerri also shared that she *‘found it hard at first’ (1.2 X100).* She related that she thought that babies would be *‘less demanding’*, she had expected that you fed them a couple of times a day, changed their nappy, put them to sleep and had *‘the rest of the day to yourself’* (1.2 X100). Likewise Angela had thought her baby would feed every three to four hours and was surprised to find she was having days where her baby would want to feed every hour. She made the following comments on the frequent feeds and the other care tasks required: ‘*I didn’t realise it would be so time consuming and then ... having to give him a bath, getting him dressed, change his bum…*’ (2.2 A.86). Angela continued to describe being a mother as *‘really hard actually, because a lot of it is guess work’* (2.2 A91).

At the final 8 week interview Angela painted a vivid word picture of her lived experience of mothering on that morning:

> *... so you sort of get up and you’re at it straight away. I feed him and that’s another half hour gone and then you’ve got to bath him and... Here I am at eleven o’clock and I’m still in my pyjamas (laughs) I’ve just had a shower and my hair is dripping wet (laughs). You*

know, typical new mother, but I'm getting better. Some days I'm more organised than others (2.3 A4).

Some of the 'hardness' and difficulty involved in learning to mother for a number of these participants in the early postnatal period seemed to be related to a discrepancy between their expectations of early motherhood and the reality of caring for a newborn infant. Angela reflected that the whole process of having a baby and learning to mother was quite different to what she expected. She mused: *'I don't know, maybe I expected champagne and roses. I got dirty nappies and a crying baby instead'* (laughs) (2.3 A77).

'It's a different way of life …'

An important aspect of learning to mother was the integration of the baby into the mother's life. While some participants spoke about consciously planning how they would integrate their baby into their daily life and world in the antenatal period, for others it was something that emerged more distinctly after the birth of the baby. For example, Gail spent a lot of time mentally preparing herself for including her child in her daily activities. During late pregnancy she contemplated and explored how she would include her baby in her activities, from household responsibilities to going out.

For other participants integrating their baby involved a preference to maintain a physical closeness to their baby. Some participants spoke about this in terms of having their baby close to them or in their bed so they do not feel that far away. Sarah explained that she put her baby in his cot the first night home but she thought *'No, you're too far away'* (4.2 S108). At another level the notion of Sarah integrating her baby into her life is illustrated by the dilemma she confronted of deciding between returning to work to have an income for her and her son, or foregoing a wage to stay at home and watch her child grow up. Sarah explained that she wanted to be there for the first time he sits or crawls, but at the same time have enough funds to send him to university if he wanted to go (4.2 S80-85).

An interesting observation made during the 26 postnatal visits was that there were significant changes in the homes of the participants compared to the initial visit. The residence of the baby in each home was physically evident by the array of baby furniture and items that were now utilised daily. Some women described experimenting with different set ups of furniture and then rearranging things to better suit their needs. Cradles and cots, prams, play mats,

change tables, piles of fresh nappies or newly laundered baby clothes, bibs, breast pumps and feeding bottles declared the presence of a baby in the home.

As life settled down for participants after coming home from hospital and they became able to interpret their baby's needs, most developed a kind of routine. The comment 'I'm getting into a routine' seemed to point towards participants developing a sense of control. Gail nicely described what learning to mother was like for her: *'It's a different way of life I suppose. You just change the way you think. Everything goes around the baby now'* (7.2 G104).

Further, participants reported that becoming a parent was an enormous responsibility where there is a shift from just thinking about yourself and your partner to being responsible for another person.

> *It's huge. All of a sudden I suppose. From just thinking about yourself or Bob and I… like you spend half an hour just thinking about the baby. And got this? Got that? Got that? And then it's okay, now me. So it is a huge thing. Coz there's no lead up to it. It's not like you know, you have a baby for a couple of weeks and you go 'okay, yep, I'm prepared now. I've gone through the lesson' (laughs)* (7.2 G107).

Participants also spoke about the experience of accepting responsibility for the baby as being intertwined with integrating the baby into their life. For some of the women, having a newborn baby solely dependent on them weighed heavily. One woman's husband was ill when she was discharged home with her baby. She described feeling '*torn in two'* as she tried to care for both her husband and her baby. At one stage she had to make the decision to focus on her baby, as her baby was totally dependent on her, and she sought help from her extended family to assist in caring for her husband. Another participant felt she had to choose between her baby's wellbeing and her partner. She was concerned for her baby's safety as her partner was using marijuana. This woman expressed that she felt responsible for ensuring her baby's safety and so left her partner and limited his access to their baby to when he was unaffected by alcohol or drugs.

In the goal to seek out the essence of the early motherhood experience it seemed that women's stories were in a sense left suspended. Although most participants found the early weeks after childbirth, they progressed in gaining confidence and knowledge about learning to

mother. This progress also reflects the integration of the babies into their mothers' lives. For example Rose shared:

> *Now it's so much better. I look forward to feeding her. I feel… happy now because… my emotions are a lot more settled (laughs) because we sort of know what we're doing and I feel like I know what I'm doing and it's much easier (5.2 R 95).*

Other participants similarly found things much easier as the weeks went on. Developing a routine and gaining confidence assisted with this. Nevertheless, some remained a little ambivalent. Gail confessed:

> *Sometimes I sit there and think 'yeah I'm coping all right'. Other days you sit there and think 'oh no'. As I said this week now I'm in a routine and she's more on the hours of what she's doing and sleeping and feeding it's become a whole lot easier. A whole lot easier* (7.2 G140).

Synthesis: Learning to Mother

The existential tenants of lived body and lived other were intermingled through the insights about learning to mother (van Manen 1997). Learning to mother was a profound and intense experience with emotions fluctuating. Joy, wonder and pleasure were juxtaposed with feeling overwhelmed, not being able to cope and concerns about postnatal depression. There were many situations where participants didn't really know what to do to manage issues such as infant crying or helping to settle their baby to sleep. Lack of knowledge was compromised further by uncertainty or confusion. Women were distressed themselves to hear their baby cry. Women had expected being a mother to be difficult, but experienced that it was much harder than expected. There was a clash between their expectations and the reality of caring for a newborn infant.

While women received information antenatally about labour, birth and pain relief there were perceived areas of gap. These include emotional changes in the first week, passing blood clots and breastfeeding being painful or difficult for some. Gaps in information about infant care included normal newborn behaviour, feeding patterns, maintaining breast milk supply and settling strategies. Becoming a mother involved a shift from women just thinking about themselves and their partner to being responsible for a vulnerable new baby that they need to

integrate into their life. For most everything now revolves around the baby. Women became more confident in their mothering as their understanding and experience increased and emotions settled.

The insights indicate that learning to mother was not an easy transition for these participants. Relationship changes will be explored in the next section.

Relationships

The theme of relationships was found to be important in both postnatal interviews. Insights regarding participant's experience of relationships with their partner, baby, own mother and others will be presented. It is however appropriate at this point to first report on the subtheme of becoming a family.

Becoming a Family

The theme of the 'becoming a family' was highlighted in the birth stories shared by participants and presented in chapter six. Following the birth of the baby most participants and their partners celebrated the beginning of their family. In the early hours after the birth many participants spoke of emotional relief and joy to have become a family. Interestingly, this concept of the developing family did not emerge as a central issue or key theme across the postnatal period. It was significant due to its absence, particularly considering it was recognised as important around the birth. While the couple had become a family in the physical and biological sense with the birth of the baby, in an emotional sense most participants were busy with a myriad of tasks that did not usually include the evolving family. Instead, the relationships in the family unit were more dynamic and primarily preoccupied with meeting the needs of the baby, 'learning to feed', 'learning to mother', maternal physical recovery and interacting with family and friends.

Women's Relationship with their Partner

Almost all participants were in a couple relationship at the time of their baby's birth. Most were married, two participants were in defacto relationships and one participant was single. Almost all coupled participants were supported by their husband/partner after the birth of their baby during their postnatal hospital stay and in the early weeks after the birth. The birth of their baby was generally considered by almost all to bring couples closer together in their relationship and to be a profound and life changing event. Gail noted that their baby was: *'... something that we created. Something we will always share between the two of us'* (7.2 G58). Xerri felt that having a baby had not brought them closer as a couple as they have always had a strong relationship. However having a baby had given them a common bond *'this is our baby ... it's not just me and Thomas anymore. It's me and Thomas and this child that we created...'* (1.3 X 61).

Relationship Issues

One exception to this was the experience of Sarah, a single parent. Sarah described being in a state of ambiguity. '*Not knowing'* about the extent of involvement the father of her baby wished to have was difficult and left questions unanswered. For instance, should the baby's father's name be on the birth certificate? When Sarah phoned the father of her baby on the day after the birth to let him know the baby was born, he said he would telephone back as he was out at that time; but Sarah had not heard from him five days later and when she phoned again he was interstate. At the final interview the father of the baby still had not seen the baby and they had some heated arguments over the phone about completing the birth paperwork and paternity tests. Sarah described the situation as '*Hard. Very hard'* (4.3 S35). Sarah commented that she was careful to avoid the relationship getting *'really nasty'* as she believed it will eventually *'blow over'* and he will want to be friends (4.3 S36). She was mindful of the possibility of him wanting contact or access to their child at a later time and wanting to avoid awkwardness.

Likewise Jess experienced some relationship difficulties with her partner after discharge from hospital and they separated. Jess felt that Fred was immature and careless about holding baby Jamie. Jess also had concerns about his substance use as Fred smoked 'dope' and Jess did not want him around their baby while he was stoned or had been drinking alcohol as she was concerned about her baby's safety and her being dropped. Jess had asked Fred to choose

between drug use and being with her and their baby. At the final postnatal interview Fred and Jess were still *'no longer together'* but Jess shared that *'he's making a big effort now… he's coming around all the time. He's stopped smoking, so he tells me'* (3.3 J62). Jess commented that she was taking *'each day as they come'* and Fred was presently visiting her and Jamie every day at Jess' parent's home (3.3 J62-65). Jess observed that her relationship with Fred was *'getting stronger whereas before she did not want to have anything to do with him' (*3.3 J69). Jess cautioned that she was *'scared that if I do go back to him it's just going to go back to the way it was.'* She shared her goal for her baby. *'I just want to watch out for her and try and make all the right decisions for her'* (3.3 J70). Jess was working through the dilemma of wanting her baby to be with both parents yet at the same time protecting her from an environment of substance abuse.

The other participants shared in varying degrees about the level of involvement of their partners in supporting them and sharing baby care. All participants appeared to be appreciative of any help they received. This help ranged from occasional nappy changes and help with night feeds to extensive support with a wide range of baby care activities. Many participants had their partner/husband home for a few days to several weeks after discharge from hospital. Most husbands/partners were the main source of emotional support for participants after discharge.

There were some participants that divulged some increased irritability and crankiness in their relationship with their partner. Dianne for example, commented that having a baby has brought them closer together as a couple, but at the same time they *'snap at each other a bit more'* when they are tired (12.3 D66). As it was usually Dianne who did the night time parenting it was Carl who had *'his head rip[ped] off for no reason'* (12.3 D66). Dianne shared that they did not have any major problems and it was all forgotten quickly.

For some participants, maintaining their adult couple relationship was difficult. Going out on a date was not feasible for those without family close by, but time as a couple was preserved by some by watching a movie together, having a glass of wine and making sure they chat about their day and do not just talk about *'baby stuff'* (5.3 R50). Rose shared that she had to '*catch*' herself from talking about her baby and instead listen to what her husband wanted to share (5.3 R53). Hayley described her relationship with her husband as mostly unchanged, but noted it was *'probably a little harder to get time alone'* (13.2 H179). She explained that this was probably more due to visitors rather than their baby.

Communication

Communication was identified as a key theme concerning participant's relationships with their husband/partner. One participant, Kate, described her relationships with her husband as *'strained at the moment'* during the final interview (10.3 K127). She described it as due to tiredness and lack of intimacy as *'it is hard to have time just to ourselves ... especially with him on nightshift'* (10.3 K128). When her baby is in bed, her husband is either sleeping as well or is at work. There was a very small period of maybe an hour when the baby is in bed before Jack went to work. They have been trying to make some time after his night shift to talk together (10.3 K129). In terms of their couple relationship Bernadette said she was very aware of the importance of keeping the *'lines of communication more open than ever before'* (9.3 B131). She and her partner were planning to sit down once per week and *'chat about us'* as having a baby *'definitely has the potential to change your love life'* and they wanted to maintain their couple relationship (9.3 B131).

The topic of intimacy was only raised by a few participants. Sleeping locations had an impact on intimacy as several couples slept in separate rooms in the early weeks after their baby was born. This was done to maximise sleep for husbands/partners who were travelling distances to work or operating heavy machinery. Some couples continued this for more than eight weeks. For some participants sexual relationships were deferred from late pregnancy due to hypertension and after the birth due to caesarean surgery or traumatic vaginal births. Lee-ann for example, described a long period when she was unable to be intimate with her partner but shared *'it was good when we finally got the chance to be intimate ... it sort of helped us as a couple [to] bond'* (11.3 L122). At the eight week interview she was still sleeping in the nursery with her baby. Dianne experienced a third degree tear after her baby experienced shoulder dystocia during a difficult obstetric forceps delivery. She shared that she had pain and some bleeding after she and her husband attempted intercourse about eight weeks after the birth. Dianne felt they might leave it another month or so before trying again as it *'actually flared up again and got quite sore'* afterwards (12.3 D37). Some participants had not resumed a sexual relationship at the time of the late postnatal interview and others did not discuss it.

Negotiating Help at Home

'*Asking for help'* was an issue for some participants. Some participants were not used to asking for help and were hesitant to ask their partners to do things when they were on '*holidays*' (6.3 C100). Women who were used to doing everything themselves said they found it easier to *'just do it'* (6.3 C111). However, for Christie, having her husband give bottle feeds overnight for one night (two feeds) *'made a huge difference'* when she felt unwell (6.3 C109). However Christie still felt the need to get up and check that her partner was alright with the feeds. Ursula shared that her husband wanted to be a *'hands-on'* dad, but that she did the night time parenting as she was concerned about him driving home and she at least could attempt to sleep during the day.

Expectations concerning housework were renegotiated by some participants. Lee-ann related that her partner had difficulty understanding that it can be hard to get household tasks done with a new baby. His comment, *'you haven't done much today'* triggered a long explanation and description intended to increase his understanding (11.3 L102). Household tasks were shared on an agreed basis in some cases. For Gail this included cleaning through the whole house together one morning a week to make it easier for her during the rest of the week (7.2 G93). In the early weeks of motherhood Dianne's husband cooked dinner each night and cleaned up afterwards while she fed or settled their baby. She would eat one handed, and then he would hold the baby while she finished her meal (12.2 D76). This sharing of the tasks continued as later she cooked while her husband settled their baby for bed (12.3 D67-69).
For some participants having time out or away was a problem when this was not equitably shared. For instance, Kate's husband Jack went away camping on a weekend in the postnatal period, and Kate felt resentful *'it's alright for you to do stuff like that but I can't'* (10.3 K135). Kate said she only got *'bits and pieces'* of time for herself (10.3 K136).

Shared parenting was a feature of some relationships. Many participants were quite exhausted in the early weeks and their husbands/partners shared the parenting to varying degrees. This partly related to both mothers and partners to get some sleep. For example, one couple took turns with night formula feeds and Rose commented *'it's such a good thing to get that extra sleep'* (5.3 R17). At the two week interview Hayley revealed that having her husband change her baby during night breastfeeds was *'a big help'*. During the 8 week interview Hayley shared that both she and Hayden were mutually concerned for each other and resolved to share the parenting work. Hayley was concerned that her husband would get enough sleep as

he had to get up early and drive a long distance to work. He was concerned about her being up late and not getting enough sleep (13.3 H151-H154). Consequently this couple shared the workload; for instance they usually bathed the baby together.

Sharing the parenting was problematic at times for some couples. Knowing the baby and understanding the nuances of care sometimes caused conflict if the participant wanted to supervise her husband or partner. Lee-ann related that she and her partner had a *'tiff'*. She related Jeffrey's complaint *'you keep telling me not to do this and not to do that, you're not letting me try and work things out for myself'* (11.3 L49). For Lee-ann the issue was that when Jeffrey did not know how to settle their baby he got frustrated and when he got frustrated he raised his voice more, which meant the baby picked up his frustration and increased her crying (11.3 L49).

Women's Relationships with their Baby

All participants shared their experience of having positive feelings toward their new baby. The themes revealed here included the experience of falling in love, 'bonding as a gradual thing,' and 'getting to know you, my baby.'

Falling in Love

A number of participants described '*falling in love'* with their new baby. Xerri said *'I love her to tears' ... 'She copies your facial expressions ... you pout at her and she pouts back, you scrunch up face up, she scrunches hers up'* (1.2 X92-93). When her baby looked at her, Xerri reflected *'it's just heart melting. It's beautiful and she's just really warm. She looks up at you sometimes and gives you little smiles and ... just the way she looks at you. She completely trusts us'* (1.3 X47). At the final interview at eight weeks most babies were smiling. Angela offered a word picture of her son's smile which demonstrated the love she had: *'his eyes light up ... he's beautiful when he smiles, but I think he's beautiful anyway. And he normally has a bit of an 'ah' when he gives a smile'* (2.3 A19).

The development of a strong bond between mother and baby was a component of most participants' experience of establishing a relationship with their baby; and the baby's smile was a large part of this. Gail depicted receiving a smile from her baby

'It's amazing, it's the best feeling. It just melts your heart, just a little smile. And knowing that she's smiling at you, it's not just a smile at something around... So when she starts looking and smiling and laugh when you talk to her and play with her it's just exciting' (7.3 G30).

Gail added that she could just sit and watch her baby *'all day'* (7.3 G32). This was echoed by some of the other participants. Lee-ann shared that she spends time every afternoon just holding and studying her baby, but that she could spend *'the entire day just looking at her'* (11.2 L44-46). Lee-ann reported being amazed as she did not expect to *'be such a doting mum'* (11.2 L 46). She recounted an interaction with her baby a few days previous: *'I gave her a kiss and blurt a raspberry on her cheek and she gave me the biggest smile. I was so rapt. I was as proud as punch'* (10.2 L49).

In addition, participant's tended to admire their baby's features in detail, which was part of the process of falling in love. Angela thought her baby had a:

'beautiful bottom lip. He's got big hands too, I don't know where they came from. Long fingers… [His feet are] small. But his hands quite large. He hasn't really lost any of his hair yet which I thought he would have. He nearly needs a haircut' (2.3 A73-74).

Likewise, Lee-ann was happy to have her baby and thought *'she is gorgeous. She's got a little button nose, perfect little lips, perfect little tiny fingers, tiny little chubby cheeks'* (11.2 L210-211).

The process of falling in love appeared to be reciprocated. For example**,** Sarah chatted to her baby during the eight week interview and she commented that they had great conversations. His face just lit up while he was looking at his mother (4.3 S79-80). During many of the eight week interviews infants were observed to study or focus on their mothers' faces, vocalise and respond to settling.

'I didn't really connect with her'

Not all participants however fell in love with their babies immediately. For some, developing a warm and loving relationship with their baby took a little time. For instance, Rose described not really connecting with her baby during the time she spent in hospital. She attributed this to

the baby being sleepy from Pethidine and then crying a lot with being hungry. She divulged: *'I just felt like I didn't really connect with her … it was only when we came home that I felt that connection a bit more'* (5.2 R75-76). Rose grew to know her baby quickly once she was home. She learnt that her baby liked baths and massages and having her head stroked. The warmth of their relationship was captured in Rose's word image of her baby: *'Every time I look at her I just think 'cutie-pie'* (5.2 R123).

Bonding was also delayed a little while for several other participants. Ursula shared: *'I think the bonding is a gradual thing for me. I didn't get that initial bonding experience in hospital. But now it's getting easier with the breastfeeding I'm really enjoying it'* (8.2 U119). It was a similar situation for Bernadette, who disclosed that she studied her baby in labour ward. She shared her observation:

> *He was really bruised because they had to turn him in my pelvis. So his eyes were bruised and his nose looked broken and he looked like he'd been through a few rounds of boxing matches … So I didn't get that overwhelming feeling 'oh look at my little baby'. I was just like 'woo, you're bruised and battered and you've got a cone head and your poor mum couldn't push you out'* (9.2 B64).

Likewise Jess did not feel connected to her baby in the early days. As mentioned earlier, Jess described having the baby blues and crying for several days just after birth. Although her baby was nursed at her bedside she initially needed some help to feed and care for her baby. She shared that: *'I just felt like I was rejecting her'* (3.1 J119). Jess commented that it was about three weeks after giving birth when she first began to feel a bit better and able to enjoy holding her baby. Once the connection and bonding began Jess shared that holding her baby was '*wonderful.*' and '*I just want to cuddle her all night*' (3.2 J 82-83).

Getting to know You, My Baby

Establishing a relationship with anyone, including a new baby, takes a little time. Recognising baby cries and interpreting infant communications were steps for participants to build a relationship with their baby. Many participants initially had trouble distinguishing when their baby had 'wind' and when they were smiling. At the eight week interview Hayley shared that her baby had begun smiling a few weeks ago. She noted: *'It was sort of a bit hard to tell in the beginning whether it was just wind or whether she was smiling'* (13.3H96). This was

echoed by other participants. Kate commented that her baby's smiling was *'definitely full on'* by six weeks and would be responsive to smiles she offered. Receiving a smile was *'...great. It just melts your heart (laughs). It's beautiful'* (10.3 K9-10).

In a similar fashion, most participants initially found understanding baby cries and interpreting their meanings challenging. At the two week interview Xerri admitted that *'Sometimes I don't understand her cries'* but shared that she was learning to interpret some of them. She identified her baby's pain cry as *'a definite shriek ... a real 'I need to be picked up' cry'* (1.3 X33). Xerri could also identify her daughter Rose's hungry cry; this was not really a cry, more of a *'whinge'*. When her nappy needed changing due to *'a poo-y bum'* she had a *'definite cry, but it's not a pain cry'* (1.3 X33). Xerri recounted that when her baby was signalling for attention, she communicated by *'a little bit of a grizzle every now and then'* (1.3 X33). From this Xerri described how she worked out what her baby needed when she was a little upset. This involved taking time to listen to and observe Rose thoughtfully, rather than responding without thinking.

Likewise Hayley discussed how she was learning to recognise some of the different cries her baby made. The wind cry usually occurred at night and involved *'an hour of screaming.'* When her baby was overtired and put to bed she would *'sort of cry and not settle as well.'* Another cry Hayley had identified was a 'come and get me' cry. This cry occurred when her baby was in bed and was not an upset cry. Hayley said that when she went in to her baby she would just look at her and seem to observe *'Oh it worked'* (13.3 H98-99). Hayley's baby became unsettled and began to cry during one interview conversation. Hayley responded to her baby by talking to her as she held her and trying to soothe her. As the conversation resumed she commented that she was looking forward to her baby *'being more active and ... being able to interact with [her and her husband]'* (13.3 H197).

At the eight week interview Bernadette acknowledged that she was still getting to know what her son liked and learning to read his cues. For example, she could identify that sometimes he wanted to be cuddled and sometimes he wanted to have space. Bernadette shared that she was learning that she did not know who he was yet, but knows that her baby is good at expressing what he wants (9.3 B152). For example, he would cry to communicate if he was unhappy about something, or smile and vocalise when he was content. While there were communications she was still learning to interpret, she could recognise when he was unhappy.

As participants gained confidence in mothering, responsive feedback from their infants was affirming. Lee-ann commented that it really helped when *'you feel like you're doing something right.'* She noted: *'If she's responding to me as she is and settling as she is, then I must be doing something right'* (11.3 L54-55). Bernadette described it as *'exciting to learn'* about her baby's behaviour and temperament. She said *'it's been lovely just to look into his eyes and think 'who are you and what are you all about?'* (9.2 B103). She anticipated looking forward to discovering who her son is and who he becomes (9.2 B104).

It's important to Have Your Mum Around

In the postnatal period participants' relationships with their own mother emerged as influencing their transition to motherhood. Some participants were very close to their own mother and almost half even had their mother present during their labour and birth. Xerri commented it was *'important to have your mum around'* (1.3 X58). She described having a strong bond between her mother and her baby and herself, and that she did not realise how much her mum would do to support her (1.3 X59-60). This included visiting at 4.30am in the morning when Xerri was distressed. Xerri would telephone her mum at home or work for advice when needed and while Xerri anticipated her mother would be supportive she had been even more supportive than expected (1.3 X57-59).

Jess was similarly supported by her mother during labour and birth and the postnatal period. Both Xerri's and Jess' mothers helped them in latching their babies to breastfeed. Jess' mother stayed with her in hospital when she was unable to sit up due to a post spinal headache, and would keep her company at night in the early weeks after discharge as she breastfed her baby. Jess commented *'I reckon I would have fallen into a heap by now if I hadn't had mum around'* (3.2 J76), and noted that her mum helped her with *'everything'* and had been *'excellent'* (3.2 J64-65).

Many of the other participants reported supportive relationships with their own mothers during the early motherhood period. Participants reported emotional support, shared joy, advice on baby care, help with settling their baby, practical support with housework and meals and babysitting. Dianne suffered significant perineal trauma with the birth of her child. She was greatly supported by her mother and her mother-in-law with cooking, meals and doing housework until she was recovered (12.3 D16-17).

Two participants reported that they did not have a close relationship with their own mother and usually had irregular contact. Interestingly this changed after the birth with both women describing increased contact from their mothers in the early weeks after the birth of their babies. For example, Gail commented that she did not get much support from her family. Her husband's family were *'fantastic'* but there is *'all this good stuff you want to share with someone… but it's not your mum so it's different'* (7.2 G87). At the two week interview Gail noted that while she did not see her parents much *'They have been up three times now since the baby was born, [two weeks ago] which is three times more than in the last six years* (7.2 G88).

A number of participants experienced their mother (grandmother of the baby) as '*missing*' or '*absent'*. Three participants had their mothers' interstate and one participant's mother lived overseas at the time when their babies were born. Two of these grandmothers travelled to visit their daughters in the early days of new motherhood. These participants described mixed emotions about spending time with their mothers. All were delighted to share their new baby with their family and many emphasised a new understanding of what their own mother had gone through in giving birth to them, particularly if they were in a posterior position. However some participants described that while their mother helped them *'a bit'*, sometimes they did not receive as much help as they had thought they would receive (11.3 L64). One of the grandmothers living interstate planned to visit when the new baby was about three months old.

Kate's mother lived overseas and Kate revealed that she missed her greatly, especially at the end of her pregnancy. She felt she needed her mother then for *'the little things. Things that you can talk about with your mum that you don't talk about with anyone else. That support and comfort of getting a cuddle from your mum. No matter how old you are'* (10.2 K195-196). After her baby was born Kate spoke with her mother daily on the telephone while she was in hospital. At the eight week interview Kate had telephone conversations with her mother weekly. Kate missed her mother immensely. At the eight week interview Kate disclosed she was feeling angry as her mother kept sending big parcels and spending a lot of money whereas Kate would have preferred her to put the money towards her plane ticket. Kate reported that her mother had sworn she would visit before her baby was six months old, but acknowledged that she had sworn to her every year since Kate came to Australia that she would visit but had not yet come (10.3 K145-146).

One participant's mother died from cancer early in her pregnancy. Angela's grief and loss were close to the surface as she made the transition to becoming a mother herself. This was particularly acute for her one morning in hospital when she described missing her mum. She recounted that:

> *'I said to my Dad 'I just want to pick up the phone and ring her' and he said 'Well you can't,' and I said 'I know, but I just want to.' And that just upset me even more …. God, she would have loved him [the baby]'* (2.2 A118).

Angela's sadness at not having her mother with her or sharing the joy of her baby is captured in this extract. In the final postnatal interview Angela had been to sort out clothing at her parents' house. Visiting the house was *'a constant reminder that mum's not there and she's not coming back'* (2.3 A8). Angela explained '*I just miss that bit of support. No one's like your mum ... you have friends and that... but it's just not the same'* (2.3 A8). Friends are supportive, but one's mother cannot be replaced.

Women's Relationships with Others

Participant's experiences of relationships were not limited to relationships with their partners, babies or mothers, but also involved relationships with others, such as visitors, community members, experts on baby care and going out with babies and new parent groups.

Visitors

Most participants reported lots of visits from extended family and friends in the early days after the birth of the baby. Grandparents, aunties, in-laws and friends were often prolific in visiting the participants in hospital and in the early days after discharge from hospital. Participants generally were happy to share their joy with visitors, although some visitors were more welcome than others.

Some participants reported having too many visitors while they were in hospital. They reported finding it difficult to juggle learning to feed and care for their newborn, and recovery from the birth. A good example came from Angela who awoke on about the fourth day after the birth of her child feeling *'miserable'* with the baby blues and *'just cried all day'* as she felt

that was the best thing to do. She described *'I had visitors and I still just sat there and cried'* (2.2 A37). She felt it was not helpful to *'pretend everything's great, because it wasn't'* (2.2 A 37). It was important to Angela to be genuine about her feelings. She believed *'It doesn't help anyone if I'm sitting there saying: '...I'm really good', when I was feeling absolutely terrible inside'* (2.2 A37).

Participants initially also experienced numerous visitors at home after discharge from hospital. The response to this was mixed. Some participants described having relatives and others *'pitching in doing things to help'* (1.2 X6), although some, mothers such as Xerri, commented that while this was good all she wanted to do was sleep or sit back and relax. Ursula similarly reported lots of visitors although she actually just enjoyed time to herself to have a sleep when possible. She shared that *'if we've got people over I feel like I've got to entertain them or talk to them' (*8.2 U119). Having lots of visitors could also be problematic if they stayed for long periods such as to 11.00pm at night. Hayley and her husband encountered this situation with extended family and found it *'a little bit harder to get time alone ...more because of visitors rather than [the] baby'* (13.2 H179).

Some participants had strained relationships with their own parents or the family of father of the baby, which made their visiting tricky. One participant, Gail, reported feeling she had to prove herself to her family. She noted:

> *Just everything has to be right so someone can't criticize me. I've had enough of that. ... You don't want anyone to think bad of you. Especially being a mum. So you don't want people to turn around and go 'my God, how's that baby going to be raised' or 'what's that baby going to be like', 'my God, did you see the house?* (7.2 G95).

Gail's comments reflected her concern to be seen by her visitors, particularly her parents, as having everything organised properly and attended to so that she could not be criticised or considered to be a bad mother. Gail's other visitors tended to telephone prior to visiting. This was much appreciated by Gail who negotiated some time to settle in prior to having visitors come to their home. She reported that she found people were very understanding noting that:

> *'...it's hard enough settling in and having friends come up in between and she's crying and you still don't know why and what you're doing. [and]... you've got to wash five million bibs like you do (laughs). It was hard that way* (7.2 G90).

Caring for a newborn, coping with multiple tasks and having a lot of visitors was difficult for some. Several participants commented that their degree of comfort with friends who were visiting depended on which friends were visiting. Friends who are relaxed or those that helped out were more welcome (7.2 G90, 8.2 U119). The next theme to be explored is that of 'the baby as a talking point.'

Baby as a talking point

An interesting aspect to having a baby was that it became public property. A number of participants described their experience of their baby being a talking point with strangers in the street. Gail shared that: *'everyone stops you …'* (7.3 G89). She related that strangers admire the baby and asked how old she is, and narrate stories of when their baby was that age (7.3 G89). Gail acknowledged it was sweet, but also did not want to be stopped by strangers just because she had a baby. She recognised it was not normal social interaction to be stopped by strangers in the street (7.3 G89).

Other participants, such as Rose, also described their baby as a talking point, or as flag for other people to talk to them. Rose shared that *'it does seem that once you have a baby people who have had kids talk to you more'* (5.3 R77). Rose found this occurred in her craft class and in the supermarket. It seemed to her that they think *'she's got a baby, she can talk now'* (5.3 R79). Rose related that these conversations tended to focus on the baby and how old she is and how things are going (5.3 R81). Rose related that people also came and spoke to her during her pregnancy, but she believed that now her baby had been born that this had increased as there was something to comment on, usually the baby's eyes or her outfit (5.3 R83).

In contrast, Bernadette reported that she loved going out walking with her baby as *'people talk more often'* which she enjoyed. She related that young teenagers hanging around at the front of shops actually moved out of the way of the pram on to the grass so that Bernadette and her baby did not have to go off the path. When Bernadette thanked them they generally beam and say *'that's alright'* (9.3 B57-61). In addition, Bernadette related that a lot of conversations were initiated by strangers during shopping trips. The butcher would ask her; *'how is he going dear?;* an elderly male neighbour enquired: *'How was your labour?… Are you breastfeeding?'* (9.3 B68-70). Bernadette said that she usually felt shy about discussing

these sorts of personal issues, but found that having been pregnant and having a baby opens up conversations that she would not otherwise have had (9.3 B70-71).

'Everyone's an expert': Babies and Unsolicited Advice

Another outcome of having a baby was that everyone wanted to give advice. Gail described receiving a barrage of unsolicited advice from friends, family and strangers during her pregnancy and after the birth of her baby. She felt that *'everyone becomes a sudden expert'* (7.3 G85). Gail found that people commented and advised on every aspect of pregnancy including the way the pregnancy was carried, and the situations that would unfold postnatally according to the personal experience of the commentators. The stream of advice flowed and is captured in Gail's account: *'You'll do this and you'll do that because that's what I did ... Make sure you rub lotion on them every time you do this… make sure you use this, make sure you do, make sure you don't use this'* (7.3 G85). Gail was irritated by this and was adamant to do things her own way.

Similarly Lee-ann recounted receiving a lot of unwanted advice, particularly from her extended family. Instructions such as not to feed her baby during the night or to just give her water and recommendations to manage wind left her surprised and frustrated (11.3 L20-21). Interestingly though Lee-ann reflected that most of the advice-givers either had never had children or had their children many years ago. As she was breastfeeding successfully and was generally able to settle her baby, she was dismayed to receive so much advice to manage problems she was not experiencing.

Going Out

The first outing after giving birth was memorable for a number of the participants. Xerri described feeling keyed up to just be out of the house and noted that the Centrelink staff even commented on how excited she appeared. When her baby became grizzly after shopping Xerri changed her baby's nappy and fed her in the back of the car. When she got out of the car to put Rose in her car seat she realised that she was standing in the car park with her clothes still undone and her breasts *'still out'* from breastfeeding (1.2 X 87-88). She felt that this illustrates that there is a lot to attend to and remember in being a new mother.

Early outings, however were often safeguarded with contingency plans. For example, identification of a main task and a secondary task(s) and the option to postpone the secondary task if the baby became unsettled. Early outings included visits to family, work colleagues, MCH centres, banking, shopping and walking. Several participants commented that it helped to get out and see other people, even if it was just for half an hour and some commented that it helped both parents and the baby (1.2 X90-91). Some participants reported using a baby sling for short outings as it was easier than taking the pram and other equipment. Interestingly Xerri described an outing without her baby and shared that she felt *'naked [and] weird.'* She understood these feelings as being due to *'she's been inside me for the last nine months or ten months or in the same room with me. So it felt really weird being away from her ...'* (1.2 X89).

Not surprisingly, going out with a baby was sometimes quite problematic. Hayley related the situation where she was going out to visit her parents who were down from Queensland (13.3 H74-77). She said she particularly wanted to look like *'I was coping really well and dressed nice'*. As she prepared to go out, Hayley's baby wet the first outfit Hayley put on when she changed her nappy. Hayley's second outfit was vomited on by the baby as Hayley fed her. Her third outfit was soiled by her baby's faeces. Finally, garments on the line that Hayley could fit into were pulled off the line by the dog, leaving her without anything nice to wear. She had to dress in older clothes that she felt did not really fit properly.

Similarly Angela described her first shopping trip on her own with her baby as *'a bloody nightmare.'* She began with a word picture of the difficulty accessing the toilet in the parents' room:

> *... I went shopping at [shopping centre] Oh God it was horrible. I had to go to the toilet. I didn't realise how hard it was to get a pram into the toilet. And like I was in the mothers' room that they have, but the actual toilet for the mother was tiny, so I had to manoeuvre this pram in. Well I got the pram in then I couldn't get passed the pram, so then I had to wheel the pram back out, reverse it in and he's screaming of course because he wanted a feed* (2.3 A25).

This excerpt depicts the hurdles this new mother encountered as she struggled to attend to her physical need to use the toilet while juggling her responsibility to keep her baby safely with

her. In the next excerpt Angela described her experience of trying to settle her baby in the pram as she walked around the shopping centre:

> *... we were walking around. Well he decided ... he didn't want to lie in the pram; he wanted to be held. So he's 'raa raa' (Angela makes sound of baby crying) so I kept putting the dummy in (laughing), rocking the pram as I was walking along and it didn't work ...I let him cry for probably twenty minutes and then I just picked him up and he was up having a good old sticky beak, and that's all he wanted. He just wanted to check everything out. And I thought 'Oh you little bugger' (laughs). So I tried to put him back in the pram and as soon as I tilt him down he'd be 'raa raa' (Angela makes sound of baby crying) and I thought 'Oh that's it, I'm going home' (laughs). We didn't get much shopping done at all* (2.3 A25).

Angela abandoned her shopping trip as it was too difficult to hold and settle her baby, push the pram and simultaneously shop. She reflected on her shopping experience and related that she *'was really disappointed ... you don't realise how hard it is.'* She commented that *'some shops don't even leave room to push a pram around the aisles'*, so you can only walk up the main aisle. Angela likes shopping, so this was frustrating to her (2.3 A25).

Mothers Group

Group programs for new parents are offered in all Victorian Maternal and Child Health Centres. These offer opportunities for both education and socialisation / networking for new parents. Bernadette related that she was initially '*terrified*' of the New Parent's group at the MCH centre and did not want to go. She had expected it to be '*daggy*' with women sitting around chatting about babies. Instead her group had a program and included learning skills like cardiopulmonary resuscitation (CPR). Despite her initial reservations, Bernadette thought the program was *'awesome,' 'really really good'* and that the MCH nurse facilitating the group was *'fantastic and ... very knowledgeable'* (9.3 B115-116). One of the group participants had a baby diagnosed with a chronic life threatening illness, which Bernadette felt put things into perspective for everyone in the group and made the mothers' group more important.

The group program took the format of an educational topic for the first hour and then afternoon tea and socialising. Bernadette said that she enjoyed sharing humour with the group and also getting support concerning her disappointment with breastfeeding. The group had an

informal mutual support benefit in that as Bernadette worked through her own grief about breastfeeding failure and began to heal a little, other women experiencing similar issues would be referred to Bernadette as someone who had been through it and understood (9.3 B119). Bernadette actually shifted from not wanting to participate in the group to being so enthused with the experience and relationships stemming from the group that she made a list of everyone's names to facilitate ongoing contact.

Likewise, Rose attended a mothers group and although it was only a small group of four mothers, found it helpful to talk to different mothers about common interests. Rose found it good to get different points of view, share common experiences and get reassurance that she was going okay (5.3 R9-14). Xerri also commented on the importance of the mothers' group at the MCH centre. She had thought mothers' groups were just about gossiping about the town but was pleased the group was going to be learning CPR and different first aid techniques around the home. It was surprising to Xerri that other group participants had normal births and were breastfeeding but that they all had completely different experiences (1.3 X92-95). Other participants had not yet joined a parent's group and were waiting for one to start.

Synthesis: Relationship Changes

The existential tenant of lived other was important in the postnatal period (van Manen 1997). Most participants felt that having a baby had brought them closer to their partners, however tiredness lead to increasing irritability in many couple relationships. Expectations about household tasks were generally renegotiated by couples, although women generally elected to assume responsibility for night time parenting**.** Lack of intimacy due to exhaustion, sleeping separately, shift work or birth injury heightened the level of frustration in some relationships. While many women described being overwhelmed with love for their new baby from birth, others experienced bonding with their baby as a relationship that gradually developed rather than being instantaneous. Women initially found it difficult to understand their baby's cries, but over a period of weeks began to recognize some communications. They were excited as their babies began to interact with smiles and cooing.

Most participants described having a supportive relationship with their own mother, receiving emotional support, help with breastfeeding and settling and practical assistance with housework and meals. Some participants' mothers were absent due to death or living

interstate or overseas, and this absence was experienced by a number of participants as difficult because of the support and comfort from their mum was seen as unique and important. The number of visitors during the hospital stay was difficult for some participants as they struggled to learn about feeding and caring for a new baby and recover from the emotional and physical experience of birth. Women revealed that having a baby opened up conversations that would not otherwise had occurred, and that a barrage of unsolicited advice accompanied the birth of the baby. Although the notion of becoming a family was celebrated in the immediate period after the birth, families were preoccupied postnatally with the physical recovery from the birth, learning to care for their baby and interacting with family and friends.

Conclusion

This chapter has presented the insights of the study concerning women's experiences of early motherhood in the postnatal period. The postnatal period was characterised by intense physical and emotional changes and challenges. The insights relating to this period of early motherhood have been grouped around themes of the physical experience of early motherhood, learning to feed, learning to mother and relationship changes. A synthesis highlighting participants lived experience of early motherhood at this time summarises each of the study insights. The next chapter will consider the themes raised in these three insights chapters in terms of the current literature and the lived experience as revealed in this study.

Chapter 8

Discussion

Introduction

Participants' experiences of early motherhood were explored in the preceding three analysis chapters. These chapters described participants' experiences of being a mother during pregnancy (chapter 5), labour and birth (chapter 6), and the postnatal period (chapter 7). This current chapter is dedicated to discussing the insights of this research project in terms of the literature. These insights can be broadly categorised into three areas; those that confirm existing knowledge about early motherhood, those that build on existing knowledge, and those that reveal new knowledge concerning early motherhood.

Much thought was involved in contemplating the structure of this discussion chapter. Consideration was given to exploring and discussing the study themes as part of a journey as some themes were present across the spectrum of pregnancy, birth and the postnatal period. Examples of this were the themes of relationships, emotional changes or 'not knowing'. This approach was seen as having merit; however concern existed about the possibility of losing some of the richness and uniqueness of themes that emerged at particular times in the transition to early motherhood. It was considered that continuing the chronological perspective was congruent with women's experiences as women themselves spoke about and framed their experiences of early motherhood in the context of pregnancy, labour and postnatal experiences. Participants did not seem to view these stages as rigid periods, but rather different phases on a continuum. This is also consistent with the key periods used to collect data and report the insights. Consequently this chapter will discuss the major research insights of this study around the chronological framework of pregnancy, birth and the postnatal period.

In this discussion chapter, a synthesis of the research will be used as a springboard to explore the study insights in terms of the literature. In order to highlight the

phenomenological insights they are presented here in bold text. Also, to enhance clarity and avoid confusion while discussing other research studies this doctoral study will be referred to as the early motherhood study or the current study.

Pregnancy

For the participants of this study contemplating pregnancy was moving toward hopes and dreams of parenthood, creating new life and beginning a family. For this cohort of pregnant women, this was also overlaid with a daunting apprehension about being responsible for a completely dependent baby.

Life Changes

Pregnancy begins a number of changes in women's lives. The insights of this early motherhood study confirm existing knowledge in the literature. For instance, Schneider's Australian study (2002) explored women's experiences of their first pregnancy with the findings revealing life changes experienced by expectant mothers involved adjusting to the pregnancy and unanticipated feelings, and reactions. Similarly, Bergum (1986) found that becoming a mother is complex, involving entering a change that is not really able to be comprehended. Bergman concluded that the pregnant woman is altered by the presence of the child and experiences a changed approach to the world.

In the current study, pregnancy resulted in a raft of changes in the participants' lives as they were transformed into pregnant mothers. Significant events took centre stage: moving house, changing jobs, taking maternity leave, adjusting to a single family income and being reliant on someone else for financial support. These insights relate to the existential tenets of lived 'time', 'space' and 'other' (van Manen 1997) and findings in the literature. Bondas and Eriksson (2001), for example noted that pregnancy and the birth of the baby involved changes for many participants in their study. These included: career break, changes in daily routines, moving to a bigger apartment or a place more suitable for children (Bondas & Eriksson 2001). In more recent times, a number of programs have been started in an attempt to assist

women in transitioning to become a mother (Chapman 2009; Department of Education and Early Childhood Development (DEECD) 2011; Kruske 2005).

In the early motherhood study participants fell into two groups: some were content to be full time mothers and others were planning to combine motherhood and employment/careers outside the home, whether for personal or financial reasons. The literature is divided on this issue. Lee and Gramotnev (2006) explored data from the Australian Longitudinal Study of Women's Health and found that over 90 per cent of young Australian women aspired to have one to two children by the age of 35, be married, and employed in paid work, full time or part time. The findings suggest young Australian women picture a future in which they will need to negotiate both motherhood and paid employment (Lee & Gramotnev 2006). In contrast, Arthur and Lee (2008) concluded in their research that motherhood, home and family were seen as more central to the lives of young Australian women than employment. This study found that although participants were in the process of obtaining professional qualifications at university most aspired to the traditional roles of wife, mother and part time work. Motherhood, home and family were seen as more central to their lives than employment.

Seeing the World Differently

The current study found that pregnancy invited reflection on what had transpired, 'seeing life differently', having increasing interest in and empathy for other mothers and being more sensitive to reports of tragedy and crisis. These insights of lived 'other' (van Manen 1997) were confirmed in the literature (Maher & Saugeres 2007, Armstrong & Pooley 2005; Bondas & Eriksson 2001). Maher and Saugeres' Victorian study reported that as women became mothers they no longer judged other mothers in a negative way. The example cited of a mother with a child crying in a public space was mirrored in the early motherhood study where Xerri shared that her reaction to mothers struggling with young children had softened and changed, with an increase in empathy for women in these situations. Research by Armstrong and Pooley (2005) found that pregnancy was a time when women's values and principles could change. This is similarly noted in the phenomenological study undertaken by Bondas

and Eriksson (2001). The authors report that participants described a heightened consciousness about their health and were touched deeply by sick or disabled children and other people's misery. The pregnant women in their study described a heightened responsibility and maturity. They also note that life gradually changed for the participants from being focused on work and leisure and a self absorbed life style to one that was more family focused (Bondas and Eriksson (2001).

Becoming a Family

The theme of beginning and becoming a family was an important life change noted in women's experiences of pregnancy in the early motherhood study. **Participants spoke of being ready for the change involved.** This insight supports what is known in the existing literature. Having a defined plan to add children to a couple relationship is supported in the Longitudinal Study of Women's Health introduced above which found that the vast majority of childless women in their twenties (around 91 per cent) plan to have children (Lee & Gramotnev 2006). A longing to create a family and to build a closer relationship with their partner were also issues raised by participants in the study by Bondas and Eriksson (2001). Maher and Saugeres note that while participants in their study described the decision to have children as a 'natural progression' many of these participants did not describe a clear process of decision making and gave uncertain and vague narratives concerning the decision making (Maher & Saugeres 2007).

Physical and Emotional Experience of Pregnancy

The experience of pregnancy was described by study participants as a very physical embodied experience with intense fluctuating emotions.

The Physical Experience of Pregnancy

Living the physical experience of pregnancy involved varying intensities of morning sickness that ranged from slight nausea to significant retching and vomiting exacerbated by smells or movement. Breast changes included tenderness

and increasing size and sensitivity. A swelling rounded abdomen declared the pregnancy publicly and made the pregnancy more real to women and their partners. Early foetal movements were mostly experienced as a fluttery sensation and increased to stronger and sharper kicks.

This physicality of pregnancy reflects the existential tenet of live 'body' (van Manen 1997). Pregnancy comprises numerous physical and psychological changes over a short period of time (Clark, Skouteris, Wertheim, Paxton & Milgrom 2009). Women's physical experiences of pregnancy have been well documented in the academic literature (Fraser & Cooper 2009; Duncombe, Wertheim, Skouteris, Paxton & Kelly 2008; Parry 2006; Armstrong & Pooley 2005; Warren & Brewis 2004; Bondas & Eriksson 2001). These experiences are also recorded in popular literature (Adelaide 1996, 1997), poetry (Harrison & Waterhouse 2009) and self-help books (Cooke 2009; Murkoff & Mazel 2008).

Morning Sickness

Morning sickness is established as a common symptom of pregnancy (Lacasse, Rey, Ferreira, Morin & Berard 2009; Fraser & Cooper 2009). A study of nausea and vomiting in early pregnancy found it affected 89 per cent of participants (Chan et al. 2011). As the early motherhood study is focused on the pregnant woman's perspective and details her experience, the information collected in the study adds a rich depth to understanding women's experiences, which is only touched on in the academic literature. The descriptions from the early motherhood study of more severe morning sickness offer deeper understanding of women's experiences. For example, the situation of smells such as toothpaste and shampoo exacerbating nausea and causing retching and vomiting; or the account of the woman pulling over to vomit in the bushes as she drove to work, vomiting again at the front gate on arrival and then walking in like normal. These images build on the description in Parry's collaborative research where the 'language, stories and descriptions' from interviews with pregnant women and new mothers are presented in a short story form providing detailed description of the physical and emotional experience of intense morning sickness (Parry 2006).

Breast Changes

Breast changes during pregnancy are reported in both the academic and popular literature. (Fraser & Cooper 2009; Pairman, Tracy, Thorogood & Pincombe 2010; Murkoff & Mazel 2008). The early motherhood study described women's experiences of breast changes, detailing increases in breast size and changes in nipple shape, breast soreness and sensitivity. The early motherhood study insights build on existing knowledge by enriching understanding of the early motherhood experience through thick descriptions. For example, some women having to buy new work shirts as their breasts increased in size so much, and the depiction of breasts being sore and sensitive that it even hurt to have a sheet on them in bed.

Body Changes

The existential tenet of 'lived body' (van Manen 1997) is further explored with the body changes of pregnancy **The early motherhood study revealed that as participants' pregnancies advanced and women's bodies increased in size and altered in shape, women sometimes bumped into objects or found it awkward to bend down low. Being physically bigger in size, carrying the weight of the pregnancy and having the baby press against body organs contributed to the physical discomfort of the pregnancy as they approached term. A myriad of discomforts emerged: back or pelvic pain, heart burn, swollen hands and feet, pressure from the baby's kicking, and difficulty rolling over in bed.**

Women's experiences of enlarged abdomen, body image issues, awkward movements, baby's movements and discomfort of a term pregnancy as identified in the early motherhood study are supported in the academic and popular literature (Pairman et al. 2010; Cooke 2009; Parry 2006;). Findings by Duncombe et al. (2008) and Earle (2003) indicate that body image remains relatively stable across pregnancy and that pregnant women may conceptualise their changing body as temporary. From another perspective, research by Warren and Brewis explored women's experience of, and attitudes towards their bodies during pregnancy (2004). They argue that pregnancy affects a women's relationship with her body (Warren & Brewis 2004). That is, women's experiences of

pregnancy can be quite diverse, with some women experiencing body changes as disconcerting or difficult (Armstrong & Poole 2005), while others thoroughly enjoy the physical changes (Warren & Brewis 2004). The early motherhood study insights were congruent with the range of experiences described in the literature.

Emotions

In the current study participants' emotions were fluctuating and heightened. Emotions ranged from slight tearfulness to a roller coaster of intense emotions. Hilarious giggling and laughter, increased irritability and grumpiness characterised some women's experiences while others felt frustrated or annoyed if they were fussed over, adding again to our understanding of lived 'body' and 'other' (van Manen 1997). Such emotional changes during pregnancy are documented extensively in the academic and popular literature (Schytt 2011; Pairman et al. 2010; Schneider 2002; Cooke 2009). The insights of the early motherhood study, therefore, confirm existing knowledge and extend it by offering descriptions of women's experiences that enrich this understanding. Interestingly, in the early motherhood study a number of participants described experiencing a range of emotions across the entire antenatal period, whereas most participants had expected this to be only during the first trimester. Some participants consequently felt their experience of being more emotional during their whole pregnancy was excessive or abnormal. This insight extends understanding of existing knowledge and has implications for antenatal education and care concerning the very wide range of individual responses that are in the spectrum of 'normal'.

Relationship Changes

The early motherhood study found that relationships during pregnancy manifested some changes, reflecting van Manen's existential tenet of lived 'other' or lived 'relationship' (1997). These will be discussed in terms of women's relationships their partner**,** baby and own mother.

Relationship with Partner

Support from partners included additional household help, protectiveness and shared communication, but this occurred to varying degrees. Some participants perceived that having a baby completed their relationship with their partner and made them more united. These insights concerning relationship changes during pregnancy are supported in the literature (Bondas & Erickson 2001; Salmela-Aro, Aunola, Saisto, Halmesmaki & Nurmi 2006). For instance, the research study by Salmela-Aro et al. concluded that overall marital satisfaction increased during pregnancy. This study revealed that those couples with a high level of marital satisfaction at the beginning of pregnancy experienced a decline over pregnancy, while those with a lower level of satisfaction in early pregnancy experienced increased satisfaction over the course of pregnancy (Salmela-Aro et al. 2006). These findings are supported by Bondas and Erikson who added that women were keen to share the pregnancy with their partner. Bondas and Erikson also found that women had certain expectations of their partner regarding housework and childcare but often did not communicate these which may cause conflict between some couples (Bondas & Erikson 2001).

The current study found that for participants who were single disclosing their pregnancy to their partner was awkward; involving anxiety, uncertainty, and procrastination. Fragile or conflicted relationships had been difficult to negotiate before the added stress of announcing a pregnancy. **Ultimately pregnancy had a significant impact on the lives of these women whether they maintained a relationship with the father of their child or not.** This was also illustrated in the Young Motherhood study undertaken by the Key Centre for Women's Health at Melbourne University (Keys 2007) and further supported in the existing literature (Leblanc 1999).

There was, however, a major relationship issue that was not raised in the early motherhood study, and this was the problem of intimate partner violence. Literature sources describe intimate partner violence as occurring in 20-25 per cent of pregnancies (Keeling & Mason 2011). While study participants did not disclose any intimate partner

violence during the study, it must be noted that they were not directly asked about this topic. To address this problem family violence screening is now incorporated in all clinical maternity and maternal and child health services in Victoria (DEECD 2011).

Relationship with Baby

In addition to exploring women's relationships with their partners, participants in the early motherhood study discussed their relationship with their unborn babies. **The study found that ultrasound images and foetal movements affirmed the presence of their baby to participants and fostered the development of a nurturing relationship.** This verifies the existing knowledge in the literature (Edwards et al. 2009; Boukydis 2006). The early motherhood study also unveiled descriptions of some women's attachment to their unborn babies during pregnancy such as loving their 'bump' (their swollen abdomen), having conversations with their baby and preoccupation with touching their abdomen and being anxious for their baby to be born. This confirms existing knowledge but also deepens it with women's rich descriptions of the confirmation of the reality of the pregnancy. There has been developing literature concerning maternal attachment in pregnancy (Rubin 1975, Leifer 1977, 1980, Lumley 1980, Cranley 1981, Condon 1985, Kemp & Page 1986, Fonagy, Steele & Steele 1991, Doan & Zimerman 2003, Cannella 2005,). In addition, specialised programs are beginning to be developed to enhance the maternal-foetal relationship where this is considered to be at risk. An example of this is the Prenatal Family and Neonatal Assessment program with adolescent mothers in Chicago, based at the Erikson Institute (Gilkerson 2006), which aims to help adolescent mothers connect with their babies antenatally. In Australia, the National Perinatal Depression Initiative and the introduction of perinatal emotional health programs in rural and regional Victoria aims to address women's emotional health in the perinatal period, including attachment issues (Beyondblue 2008; Department of Health 2010).

Significantly, the current study revealed new information about some participants' antenatal interaction with their foetus that is not detailed in the midwifery and nursing literature. This comprised participants playing games or having soothing communication and interaction with their not-yet-born babies. Specifically, the interactions involved participants in activities such as playing 'catch' with their babies feet, trying to determine foetal body parts that were active, tapping the fundus of the uterus to stimulate a response from the baby, watching 'the show' of foetal movements displayed during a bath, responding to foetal movements with conversation, and soothing an active foetus with calming words and massage to facilitate maternal sleep in the middle of the night. Half of the study participants spontaneously described these interactions. These descriptions document participants' emerging relationships with their not-yet-born babies and reveal women relating to their babies as individuals and recognising the person hood of their babies.

An extensive search of the literature on mother-foetal attachment did not find any information about interactions of this kind. The academic literature does consider interaction models, tools used to research and assess maternal-foetal attachment (Alhusen 2008; Lewis 2008; Araneda, Santelices & Farkas 2010; Sun Ji & Han 2010), but not the types of interactions described above. For example, Lewis (2008) contends that the relationship between the mother and her foetus is only unidirectional, as the foetus does not elicit a response from the mother, but only responds to her (Lewis 2008). According to Lewis, it is only the mother's perception that the foetus responds to her.

Stoppard has written a guide book for expectant parents on how to begin parenting during pregnancy, which focuses on the maternal-foetal relationship and 'bonding with your bump' (2008). Stoppard offers step by step guidelines encouraging parents to massage their baby in-utero and teach the unborn baby games such as kicking in response to verbal cues termed spaced repetition by the author (Stoppard 2008). Some details in this book are backed by the research literature but others are based on reasoning rather than evidence. While this is not academic literature, it was the only reference related to maternal-foetal interaction that was located.

Further research is indicated here as from the perspective of study participants in the early motherhood study the mothers and babies were interacting and some perceive their baby responding to them. Current research investigating foetal neurobiology suggests that the foetus may have cognitive and sensory abilities (Mares, Newman & Warren 2011). The maternal-foetal interaction described in this current study outlines the experiences of a subgroup of participants and would be useful to investigate further. This is particularly so because the maternal-foetal relationship has implications for the maternal–infant relationship, attachment and bonding and subsequent maternal and infant wellbeing (Alhusen 2008; Araneda et al. 2010).

Relationship with Own Mother

The current research also revealed that women's relationships with their own mothers assumed significance during pregnancy. These relationships were generally supportive, and most women sought and received emotional support from their mother, although others sometimes received practical or financial support. Women who usually had intermittent contact with their own mothers described increased contact from them as their pregnancy drew near term. These women responded with uncertainty and a degree of cynicism about this change in their relationship with their mother. A few women revealed feeling a sense of being smothered and some women's relationships with their own mother during pregnancy were disrupted by the tyranny of distance or loss due to death. These insights are supported in the existing literature (for example, LeBlanc 1999; and Chesler 1979). Le Blanc reports on women's positive relationships with their own mothers, the challenging ones and also the upwelling of issues from childhood that present women with conflict when they become mothers themselves. Chesler's diary of pregnancy and early motherhood also offers insights into the struggles that women can experience as they grapple with the experience of pregnancy and their relationship with their own mother. These are examples of the study insights being confirmed in the literature.

Waiting

Waiting most significantly reflects the existential tenet of lived 'time', but also incorporates lived 'space' and lived 'other' (van Manen 1997).

Insights from the current study revealed that during pregnancy waiting was enmeshed and entangled with anticipation, excitement and anxiety, and occupied a lot of time. News of the pregnancy may initially only be shared with close family and friends with public announcement postponed until after the risk of miscarriage was reduced. The academic literature does not appear to record much information concerning when women share the news of their pregnancy, although it is noted by some authors that many women will wait until the first trimester is completed when the risk of miscarriage is reduced (King & Botsford 2009; Stern & Bruschweiler-Stern 1998). Nevertheless, some women may share the news of their pregnancy publicly as soon as it is confirmed, while others may need more time to assimilate their pregnancy or may delay announcements for other reasons (King & Botsford 2009; Stern & Bruschweiler-Stern 1998). The insights of the early motherhood study are consistent with this.

The research study also identified preparing for the new baby as another important component of waiting. Women shared a new attentiveness and interest in other expectant and new mothers, and how they managed and shared learning about birth and mothering in education classes with their partners and other expectant couples. Preparing for motherhood by seeking information from education classes, clinic appointments, family and friends, books, journals or the internet is confirmed in the academic literature (Fraser and Cooper 2009, Schneider 2002) and in other literature (Chesler 1979) as activities undertaken by many pregnant mothers. Nevertheless, after the birth a number of participants in the study questioned the lack of information included in the antenatal education classes regarding looking after the baby, and gaps in information in other areas such as care of the mother after childbirth and breastfeeding issues. The content of antenatal education has been controversial in midwifery practice with it being argued in many circles that antenatally women and their partners are only focussed on the birth. An issue that seems to be missing from the literature is the situation of pregnant women who do not like to discuss birth or watch

birthing films (DVDs), or do not want to have their child placed on to their bodies after birth and prior to being washed. This did arise with one participant and adds to the understanding of the breadth of women's preferences. It is also an area for possible further study.

Preparing for Motherhood and the Baby

The current research found that preparing a place at home for the new baby involved contemplation, reflection and anticipated joy. Creating a space for the baby and organising baby clothes and equipment was a significant feature of women's experience of the transition to motherhood. This is consistent with the literature (Lundgren & Wahlberg 1999). The early motherhood study insights add to the existing knowledge concerning women's experiences of preparing for the baby. The new knowledge revealed here is the amount of time a number of participants revealed spending in the waiting period before labour began just looking at the tiny baby garments, gazing at their bassinet or cot and being reflective and contemplative. These insights add to existing knowledge and would also be a topic to explore in further study.

All participants in the study described the last weeks of pregnancy as tiresome and difficult as women waited for the baby to be born. Women perceived that they were going to be pregnant forever, reflecting van Manen's tenet of lived 'time' (1997). In the early motherhood study women's fatigue, the discomforts of a term pregnancy and waiting for the birth seemed to contribute to the very slow passage of time. Waiting was tiring and 'hard'; women felt anxious and 'completely buggered.' Eri, Blystad, Gjengedal, Blaaka (2010) explored the experience of first time mothers as they waited for the onset of labour. This phenomenological study concluded that participants moved into a 'state of active waiting' and intense awareness of their body as they drew near their due date. Likewise, a textorium on pregnancy described waiting for the birth of a child as an 'expectant waiting' (Van der Zalm 2002). The current study documented what is recognised as practice wisdom. This experience is confirmed in a range of internet sites where women journal their experiences of pregnancy via 'blogs'. Waiting in the last months of pregnancy and waiting for labour to start appear to be

perceived by many women as being 'forever pregnant' (Murkoff & Mazel 2008; Bailey 2009, Nicolie, 2009).

The early motherhood study found that participants were often extremely irritated with telephone enquiries from friends and family around term as to whether they had 'had the baby yet?' or if 'anything was happening?'. Women also felt frustrated when they reached their estimated date of delivery and had not gone into labour. This insight reveals the existential tenets of lived 'time' and lived 'other' (van Manen 1997). These issues do not appear to be addressed in the academic literature, although they are discussed in the popular literature and internet blog sites (Cooke 2009; Tiffany 2009, Donielle 2009, Xynyth 2009). This insight has implications for antenatal care and education in terms of informing expectant mothers that an estimated date of delivery is only an estimate, that birth can normally be expected to occur within two weeks either side of the estimated date. And that only an estimated 1 per cent of births actually occur on the approximate due date (Macdonald and Magill-Cuerden 2011). Preparing pregnant women to manage enquiries about the birth of their baby and managing stress should also be considered.

Wondering

The current study unveiled that women held a number of questions in their minds as their pregnancies progressed. These 'wonderings' reflected on the existentials of lived 'other', 'body' and 'time' (van Manen 1997). Family bereavements caused reflection on life and death and a wondering about the interconnectedness of life, with the ending of one life and the beginning of another. As the birthing time drew near, musings and wonderings washed over women: When would labour start? Would their partner be with them? How would the labour progress? Women also wondered and worried about their not-yet-born babies. Wondering if they would be alright, wondering if they would be healthy, if they would be able to breastfeed. Increasing reflections and ruminations crystallised the trepidation some women experienced. Women tried to imagine what being a mother was going to be like and what they would be like as mothers. Some wonderings were musings and reflections, while others were more concerns or anxieties.

The existing literature confirms these insights. For instance, Harpel (2008) found that 93 per cent of women studied reported anxiety about the wellbeing of their baby. Worries and anxieties associated with pregnancy have also been reported related to the pregnant women's health, the health of her baby and the approaching birth (Biehle & Mikelson 2011; Roesch, Dunkel-Schetter, Woo & Hobel 2004).

Furthermore, the literature documents that pregnant women are often concerned about the unknown (Dahlen & Barclay 2008). Matthias & Babrow (2007) used problematic integration theory and a case study approach to illuminate the struggles with uncertainty encountered during one woman's pregnancy. Armstrong and Pooley found that worries associated with pregnancy could be present throughout the pregnancy, although the nature of the worries varied over time (2005).

Likewise, several studies have explored women's anxieties and fears concerning childbirth (Fisher, Hauck & Fenwick 2006; Sercekus & Okumus 2009; Nilsson & Lundgren 2009). For instance, Duarte & Goncalves described participants feeling afraid they 'won't be a good mother', or wondering if 'the baby will cry a lot' (2007:257). Women also reported wondering 'What am I getting myself into?' and 'How will I be able to raise a defenceless baby?' (Duarte & Goncalves 2007: 259). These thoughts and concerns echo those reported in the early motherhood study. The early motherhood study insights, however, also add depth to the understanding concerning women's feelings by giving voice to women's concerns and recording that these are still an issue.

In addition, published diaries have revealed the emotions and fears associated with pregnancy and the transition to motherhood (Chesler 1979). While there are not many such publications available, published diaries and personal accounts intimately share real life experiences and reveal both reflection and contemplation about motherhood. The insights of the early motherhood study regarding participants' concerns and wonderings enrich understanding by adding the experience of rural Australian women to the knowledge base. As recommended by Nilsson & Lundgren (2009) the insights indicate the importance of midwives and MCH nurses exploring concerns and anxieties held by pregnant women during the antenatal period.

This concludes the discussion of the antenatal insights of the early motherhood study in terms of the contemporary literature. The next section of this chapter considers the insights from the study regarding women's experiences of labour and birth.

Labour & Birth

Is this something happening?

In the early motherhood study confusion and uncertainty pervaded the experience of recognising the onset of labour. Early labour often was not recognised as women's experiences were attributed to takeaway food or Braxton Hicks contractions. Several women were hesitant and unsure if their 'waters had broken' as they perceived the changes in their bodies as being different to the descriptions of early labour or spontaneous rupture of the membranes recalled from books or education classes.

Recognition of labour relates to van Manen's existential tenet of the lived 'body' (1997). Participants' confusion about the onset of labour seemed a surprising insight, given almost all participants attended antenatal classes. This revelation from the early motherhood study was however confirmed in one ethnographic study that found nulliparous women were confronted by the incongruence between their expectations and actual experience of the onset of labour (Beebe & Humphries 2006). Participants in Beebe and Humphries' study reported uncertainty about the onset of labour as it was happening, overlooking physical sensations or attributing them to other causes when they did not meet expectations (2006). Similarly, confusion about the onset of labour was noted by Schneider (2002:17) and Gross, Haunschild, Stoexen, Methner & Guenter (2003).

Uncertainty and confusion about the spontaneous rupture of membranes ('waters breaking') is something that seems to be known anecdotally as midwifery practice wisdom but does not appear to be detailed in the literature. This insight extends existing knowledge of women's experiences of labour as it validates what is known but does not appear to be documented. Difficulty in recognising the onset of early labour and

spontaneous rupturing of the membranes has significance for the discussion of these processes in antenatal care and education.

Description of contractions

In the current study women found the sensation of uterine contractions difficult to describe and not something that could be understood from book learning. This collection of women's descriptions of early uterine contractions was an exciting outcome of the early motherhood study, enhancing understanding of the lived 'body' (van Manen 1997). While the experience of a contraction is a unique and individual experience (Pairman et al. 2006), these insights build on existing knowledge to add a rich depiction of this phenomenon. The pain of labour has also been and written about in poetry. Harrison, for example, identifies that she had not previously 'understood the omnipotence of pain' and did not expect to encounter '… all the world's scythes' as she describes her experience of uterine contractions in labour (2009:106).

Increasing pain and duration of contractions

In the early motherhood study the pain and duration of contractions intensified as labour progressed and contractions would build to a peak and then taper down. The pain was all consuming and unrelenting but women knew that it was a pain that had a cycle and would end.

These insights reflect the tenets of lived 'body' and lived 'time' (van Manen 1997). This description of labour contractions increasing in frequency, pain and duration with the progress of labour confirms existing knowledge of the first stage of labour (Macdonald & Magill-Cuerden 2011; 401; Fraser & Cooper 2009). The course of the contractions building up to a peak and then tapering down and repeating the cycle again is also consistent with the academic literature and current understanding of labour (Green, Coupland & Kitzinger 1998; Pairman et al. 2006). Women's experience of pain during

established labour has been measured in the literature through a variety of charts, questionnaires, Likert and visual analogue scales. (Melzack & Wall 1991; Bradford & Chamberlain 1995; Moore 1997). Labour pain has also been described as rhythmic, intense, cramping, shooting, aching and stabbing (Wall & Melzack 1994), which concurs with the early motherhood study.

In the early motherhood study, while women experienced the pain of labour as powerfully strong and unremitting, most women had an awareness that the pain had a cycle that would eventually end, while others were aware that each pain brought them closer to meeting their baby. These insights are noted in the literature (Green, Coupland & Kitzinger 1998:82-83; Waldenström, Bergman & Vassell 1996; Maher 2008). For instance, Waldenström et al. (1996) explored the complexity of labour pain and attributed this to the different character and meaning of childbirth pain compared with pain associated with disease; for instance, labouring women know the pain will end and result in the birth of a baby (1996). Research by Lundgren and Dahlberg on women's experience of pain during childbirth concluded that the experience of pain and strength during childbirth gave meaning to the transition to motherhood (1998).

The Experience of Labour

Strong labour, as described in the early motherhood study, was an arduous and challenging experience. It was a physical experience that impacted on the whole body: producing shaking legs, cramping feet, breathing disordered by distress, a sense of loss of control and despondency for some who experienced long labours.

The physical experience of strong labour is well documented in the literature (Pairman et al. 2010; Fraser & Cooper 2009). Robertson, for example has documented patterns of physical and psychological behaviour during normal labour (1994). During established labour these included women avoiding conversation, resting quietly between contractions and finding their own body position. During transition sudden changes of behaviour occur with women feeling restless, out of control and wanting to go home;

then becoming calmer in second stage of labour, concentrating intensely, and seeming to have a 'second wind' (Robertson 1994). These behaviours were described in the early motherhood study by women who progressed to vaginal deliveries without epidural anaesthesia. In this area the insights of the early motherhood study extend existing knowledge by gleaning vivid descriptions of women's embodied experience.

In the current study women initially used a range of physical and psychological measures to manage the pain, with most participants later progressing to use the spectrum of medical pain relief options. The use of physical and psychological measures to ease the pain of strong labour is consistent with strategies reported in the literature, such as physical and emotional support, warm baths or comfort positions such as sitting on the toilet (Pairman et al. 2010). Other strategies to ease pain include being active, upright, walking, showers, heat packs, music and massage (Escott, Slade, Spiby et al. 2004; Cluett et al. 2002; Kimber, McNabb & Mc Court et al. 2008).

Most participants in the early motherhood study used these measures initially and then utilised the gamut of medical pain relief options such as gas, narcotic analgesia and epidural analgesia, which is consistent with the literature (Macdonald & Magill-Cuerden 2011; Fraser & Cooper 2009). Australian research showed that although women considered they were informed about labour analgesia, they were unable to describe risks or benefits of these (Raynes-Greenow, Roberts, McCaffery & Clarke 2007).

In the current study several women described a sense of altered consciousness and reduced physical mobility late in the labour. This involved being able to hear conversations about their care but being unable to participate, express themselves or respond verbally. This insight relates to van Manen's existentials of lived 'body' and lived 'other' (1997). The description of a sense of altered consciousness during strong labour is confirmed in the literature (Pairman et al. 2010). This may be due to the effects of the narcotic analgesia distorting perceptions (Fraser & Cooper 2009) or part of the experience of intense labour, such as when birthing women focus inward (Pairman et al. 2010), or the effect of the endorphins of labour (Buckley 2002: Moore 1997) or a combination of these causes. This insight from the early motherhood study

confirms existing knowledge, but supplements it with further descriptions of this phenomenon.

In the early motherhood study time was generally experienced differently during labour, with time dragging in early labour and then progressing quickly as contractions increased. The concept of experiencing time differently during labour confirms findings in a phenomenological study indicating that women's temporal experiences during the delivery process were paradoxical and fluctuating (Beck 1994). This study reported that while women were absorbed in labour, 'time seemed endless', however women were amazed and disbelieving about the amount of time that had passed (Beck 1994:249-250). Similarly, Fox observed that the 'woman in labour leaves behind quantifiable time' (1989:127). More recently, women's experience of time during labour and birthing has been investigated by Maher (2008). In this study, women's experiences of birthing time were found to be complex; with a woman bringing together 'medical' time (time bound by medical frameworks) and natural time and developing their own form of 'process' time, the amount of time it takes to complete what needs to be done (Maher 2008:130).

In the current study support from a partner via personal connection, encouragement to keep going and a sustaining presence was at the core of getting through labour. Attentive concern, caring conversation and giving physical comfort created a reassuring and safe atmosphere to labour in. Some mothers, mothers-in-law, brothers and aunts also supported women during labour, illustrating the existential of lived 'other' (van Manen 1997). Supportive care from a woman's partner or other support person is recognised as an important part of care during labour (Carlsson, Zigert, Sahlberg-Bloom & Nissen 2011; Gibbons & Thomson 2001; Klaus, Kennell, Roberston and Sosa 1986). The presence of a partner has been found to reduce pain and uncertainty, alleviate loneliness, and enhance women's strength to persevere and endure (Bondas-Salonen 1998). Support during labour has also been shown to produce improved outcomes such as shorter labour, less use of analgesia and less use instrumental or caesarean section deliveries (Gordon et al. 1999; Klaus et al. 1986; Sauls 2002). Research by Gungor and Beji (2007) confirmed that where a woman's partner actively supported them during labour and birth, women had a more positive view of their experience compared to those labouring alone. The insights

of the early motherhood study confirm existing knowledge that women found emotional support from their husband, partner or support person to be important during labour and birth; however, evidence of shorter labour and less medical intervention was not observed in the current study.

Midwifery support during labour & birth

The early motherhood study found that women valued the care of midwives in getting them through one of the hardest times in their lives. This is another example of lived 'other' being important (van Manen 1997). They also appreciated being informed about the progress of labour and management options and felt protected and in safe hands when midwives were observed to be in control. In the literature, Hunter (2009) notes that the midwife's presence with a woman during labour and birth is at the core of midwifery practice. The concept of 'being with woman' has been defined as 'the provision of emotional, physical, spiritual and psychological presence/support by a midwife as desired by the labouring woman' (Hunter 2009:111). A number of research projects have explored midwifery support and care during labour and found it to be supportive, caring and making the difference in getting through the labour (Larkin, Begley & Devane 2009; Hunter 2002, 2009; Bayes et al. 2008; Corbett & Clark; Mackinnon, McIntyre & Quance 2003). Nevertheless, in at least two studies a small number of women reported a negative experience of midwifery care in labour which diminished their experience of childbirth (Bayes, Fenwick & Hauck 2008) or contributed to anger, distress and disappointment (Baker, Choi, Henshaw & Tree 2005). The early motherhood study insights concerning positive midwifery support during labour and birth are generally consistent with the literature and positive experiences of labour and birth.

The presence of doctors during childbirth

In the current study while doctors were only briefly present during the lengthy first stage of women's labour, all participants had a doctor present when they delivered their child. Several women described moments of intense communication with their doctor during the labour or birth: deep eye contact, feeling listened to or

being affirmed. The presence of medical practitioners at all births in this small study seemed unusual for a cohort of healthy pregnant women, but is consistent with the local culture of medically managed birth and the levels of labour intervention. A state wide population based study in Victoria showed that 46.5 per cent of births had a doctor present as accoucheur; of these 7.7 per cent were general practitioners (Halliday, Ellis & Stone 1999). Intense communication with the midwife or doctor during second stage of labour has been well documented in the literature. For example, Gibbons & Thomson (2001) explored women's expectations and experiences of childbirth and found that women described increased confidence and reassurance to be cared for in labour by a midwife they knew. This confirms the early motherhood study insights.

Experience of Birth

The existential tenets of lived 'body' and lived 'other' were evident in the experience of birth (van Manen 1997). Participants in the early motherhood study described that concentrated effort was required in the second stage of labour to endure the pain of powerful contractions while laboriously pushing the baby down the birth canal. Newly born infants were placed in various locations depending on the mother's birthing position and their wellbeing. The pain of powerful contractions during childbirth has been recorded in the Old Testament of the Bible, initially as the curse of Eve (Genesis) and also in Isaiah with the verse 'I will cry out like a woman in travail. I will gasp and pant' (Isaiah 42:14). The academic literature concerned with the second stage of labour, however, focuses on the physiology of birth (Macdonald & Magill-Cuerden 2011; Fraser & Cooper 2009), birthing outcomes (Dahlen, Ryan Homer & Cooke 2007) or midwifery support (Pairman et al. 2010), rather than women's experiences. There is much less literature available concerning women's experiences of second stage of labour. The literature in this area focuses on specific interventions such as spontaneous pushing or perineal warm packs rather than women's lived experiences (Chang et al. 2011; Dahlen et al. 2009).

Furthermore, it is noted that articles titled 'Women's experiences of control in labour' or 'Women's expectations and experiences of childbirth' do not directly report on women's physical experiences from their perspective (for example O'Hare & Fallan

2011; Gibbons & Thomson 2001). There is, however, work such as Bergum's phenomenological study which have explored birthing pain as part of investigating woman's transformation from woman to mother (1986). The insights of the early motherhood study are echoed in her work, which reports women's rich descriptions of birthing pain. Similarly, this extract from a song written and performed by Fiona Latham (2005) captures aspects of this experience:

Birth is a journey leading you on
Have faith in your body, you've got to be strong
Don't lose your faith now you've got to believe
Let it lead you on and on and on …
Oh, I never knew the strength that I could find
Never knew what would be on the other side …

The insights from the current study concerning women's experiences of labour and birth extend existing midwifery knowledge by adding rich descriptions of women's experiences.

The first meeting

The current study found that the first meeting between mother and child for most participants was characterised by wonder, elation and incredulity that the baby had arrived. Others felt exhausted, dazed or flat after a prolonged labour or complicated birth and did not have any energy left to hold or engage with their baby. Overall newborn babies were perceived as warm, soft and beautiful, when introduced to their mothers, even if still covered in blood. For most women giving birth was a proud achievement; they had endured the most challenging endeavour of their lives so far.

These insights highlight the existential tenets of lived 'other' and lived 'body' (van Manen 1997). The academic literature acknowledges that the moment of birth is significant for women who may experience a range of emotions immediately after the birth ranging from elation to flatness secondary to exhaustion (Pairman et al. 2010). It is women's own stories in contemporary literature, however, that offer the rich accounts

of their experiences of the first meeting with their baby. For example, Johnson described giving birth as 'the most powerful convulsive act of my life' on meeting her newly born son as 'I could not believe all the joy my arms held, that my arms knew exactly how to hold him' (1997:191). Similar accounts are documented by Griffin (2010) who recounts Ilka's experience of her first meeting with her newborn: 'I could feel the love when they placed my little girl on my chest. I will never forget her bright-eyed, inquisitive, exquisitely beautiful face.'(Griffin 2010:70). The antithesis of these experiences is depicted by Moody (1997) as she described meeting her baby after his rapid birth. She notes he breathed alone 'but was very blue from oxygen deprivation during the labour' and she had 'never felt such fright and desolation' (1997:17). The insights from the current study add rich description to the small body of literature concerning women's experience of the first meeting with their baby.

Blood

In the early motherhood study a number of women were surprised by the amount of blood accompanying childbirth. Several yearned for a shower and described the hot water that soothed and cleaned their skin as almost holy. This insight again reflects the physicality of birth and the existential of lived 'body' (van Manen 1997). Interestingly those commenting on the amount of blood generally had a birth where blood loss was in the normal range, while those who had postpartum haemorrhages did not comment on the extent of blood present at the birth. Women's experiences of observing the presence of blood at birth does not appear to be discussed in the literature, except in terms of postpartum haemorrhage. This has implications for antenatal education and preparing women for birth.

Birth in a Technological Age

A number of medical interventions were experienced by this cohort of participants. This insight highlights the existential tenet of lived 'body' and lived 'space' (van Manen 1997). These included induction of labour with prostin gel or tape, or with Syntocinon infusions, which were also used to augment labour if required. Foetal monitoring with a cardiotocograph (CTG) machine required

women to be lying down or sitting and having straps encircling their abdomen. Anxiety and worry increased for some women as the audio signal of the foetal heart rate was heard to slow, or they observed the graphs of the contractions. Antenatally most women articulated concerns and fears about epidural anaesthesia but found it to be a great relief if they became exhausted or distressed with a prolonged labour. Many women having an epidural progressed to an instrumental delivery. Most significantly the use of technology such as intravenous lines, CTG machines and epidurals were confining and irksome, restricting movement and comfort measures such as walking around, or use of showers. Two participants underwent an emergency caesarean birth and experienced a myriad of concerns as they were prepared for surgery. They did not experience any pain during the surgical procedure but were aware of pushing and pulling and prodding and their whole body jerking around. Participants having caesarean births were not able to hold their baby until in recovery or arriving on the postnatal ward.

The rising rates of technological intervention in childbirth are well documented (McAra-Couper, Jones & Smythe 2010; McNally, Hilder & Sullivan 2011; Cherniak & Fisher 2008). The distinction between what is considered a normal birth and what is usual practice is becoming blurred (Werkmeister, Jokinen, Mahmood & Newburn 2008). For instance, official terminology for classifying birth has recently been changed from 'spontaneous vaginal' birth to 'non instrumental vaginal' birth; which seems to reflect how intervention and technology are now embedded in the birthing process (McNally et al. 2011). This reaffirms the suggestion that within the medical paradigm birth is only considered normal in retrospect (Cherniak & Fisher 2008).

Birthing interventions can occur in stages and have been termed the cascade of interventions (Roberts, Tracy and Peat 2000; Zwelling 2008:87). The cascade of intervention, for example, often begins with induction of labour and then progresses to the insertion of intravenous lines and electronic foetal monitoring (Roberts et al. 2000). This limits movement so pain is increased and an epidural may be administered leading to immobility and bed rest. Epidural analgesia during labour has been identified with interventions such as high rates of instrumental delivery and perineal trauma (Roberts et al. 2000). A number of participants in the early motherhood study experienced

significant interventions and complications that fit the blueprint for cascading interventions.

The literature concerning medical interventions during labour, such as induction of labour, instrumental delivery or epidural analgesia generally focuses on the birthing outcomes and comparisons of techniques and statistics, rather than women's experiences (Chiossi, Verocchi, Venturini & Facchinetti 2006; Dahlen, Ryan, Homer & Cooke 2007; Knight et al. 2009). The exception to this is the literature on caesarean birth. Qualitative research concerning women's experiences of caesarean birth has considered a range of issues such as unplanned caesarean (Roux & Van Rensberg 2011) or physical recovery after caesarean birth (Kealy, Small & Liamputtong 2010; Fenwick, Holloway & Alexander 2009). The study by Kealy et al. for instance, concluded that participants reported a variety of 'unanticipated and unwanted negative health outcomes' with caesarean birth (2010:1). This diverges with the experience of participants in the early motherhood study who did not identify any complications. The current study did, however confirm findings in the literature that women felt frustrated with the physical limitations and slower physical recovery associated with caesarean birth.

Furthermore, the early motherhood study found that women experienced the involvement of technology during labour to be restrictive and irksome. This applied to women experiencing interventions ranging from induction, cardiotocography (CTG), intravenous infusions and epidural analgesia and is confirmed in the literature. Labouring women connected to a CTG machine had their movement during labour severely restricted; for example being unable to change positions, use the shower or bath or walk around (Grivell, Alfirevic, Gyte & Devane 2010). The early motherhood study also highlighted some participants' concern and distress due to seeing and hearing the slowing of the foetal heart rate. Although hospital staff attempted to minimise this by turning the machine volume down or concealing the contraction graph after a baby was distressed, this is probably of questionable effectiveness as labouring women were already fearful and concerned about the welfare of their babies. This insight extends knowledge of women's experiences of this intervention.

In the current study, women's concerns about risks and complications of epidurals, in particular paralysis, were quite significant during the antenatal interview. Women were keen to avoid epidurals because of this possible danger. The risk of paralysis with epidural analgesia is cited as 1 in 100,000 in the literature (Pairman et al. 2010), which in everyday terms is comparable to the risk of being murdered. There was a significant disparity between women's fear of complications from epidural analgesia and the statistical likelihood that they will occur. Furthermore, there was also a contrast between women's serious concerns antenatally and the number of women who accepted epidurals during labour and found them extremely effective in relieving pain. This insight of the current study adds to the body of knowledge regarding women's concerns with epidurals in labour.

This completes the discussion of the early motherhood study insights of women's experiences of labour and birth in terms of the contemporary literature. The final section of this chapter considers the insights from the study regarding women's postnatal experiences of early motherhood.

Postnatal

The postnatal insights from the early motherhood study will be discussed in terms of the 'physical experience of early motherhood', the 'experience of breastfeeding', 'learning to mother' and 'relationships'.

The Physical Experience of Early Motherhood

The early motherhood study found that while some participants felt physically well after the birth of the baby, many participants initially experienced weakness, fatigue, and limited movement due to perineal pain, caesarean wounds or, in one case, a spinal headache. Perineal sutures were described as very painful, causing women to feel swollen and bruised. For participants with third degree tears the pain and discomfort was multiplied several fold and women initially had difficulty

walking to a chair and compared the pain to having little knives stabbing them and involving intense perineal pressure with just laughing or coughing. The postnatal period disclosed the existential tenet of the lived 'body' (van Manen 1997).

There is an emerging literature focussing on women's physical health literature in the twelve months after childbirth (Chien, Tai, Hwang & Huang 2009; Webb, Bloch, Coyne, Chung, Bennett & Culhane 2008; Cheng & Li 2008; Brown, Lumley, Macdonald & Krastev 2006; Schytt, Lindmark & Waldenström 2005). This literature explores the 'lived body' and indicates that women experience an array of physical health issues postnatally, with reports of 69 per cent experiencing at least one physical health problem after birth (Webb et al. 2008) and 96 per cent of women reporting at least one health problem in the first 8 weeks after birth (Ansara, Cohen, Gallop, Kung & Schei 2005; Thompson et al. 2002). Tiredness, back ache, haemorrhoids, constipation and urinary incontinence were commonly reported problems (Schytt et al. 2005; Webb et al. 2008). Other frequent health problems were perineum pain, caesarean wound pain, mastitis or breast engorgement and more coughs and colds than usual (Cheng & Li 2008; Schytt et al. 2005). Pain during sexual intercourse (Cheng & Li 2008; Barrett, Pendry, Peacock, Victor, Thakar & Manyanda 2000) and faecal incontinence were also identified as health issues postpartum (Schytt et al. 2005). In addition, the method of birth was reported as having an impact on postpartum health problems (Thompson et al. 2002; Brown & Lumley 1998). For example, in their population based Canberra study, Thompson et al. (2002) found that women having a forceps or vacuum extraction birth reported more perineal pain and sexual problems than women having a spontaneous vaginal birth, after adjustments were made for parity, perineal trauma and duration of labour. Thus the insights of the current study are confirmed in the literature concerning the women's physical health after childbirth. Similarly this current study confirmed that the physical experience of new motherhood varied with the experience of childbirth and the level of medical intervention. Significant issues identified were perineal trauma and injury, caesarean wound pain and postpartum haemorrhage. Postnatal body changes affecting the breasts, voiding, use of the bowels and the abdomen were also identified as affecting women's experiences of early motherhood.

A review of the literature located numerous papers concerning perineal trauma (Ansara et al. 2005; Cheng & Li 2008; Webb et al 2008). The topic of women's experiences of

perineal trauma and pain are mostly considered, however, as a secondary topic. Steen's doctoral study was the only research that was located which focused primarily on women's experiences of perineal pain after childbirth. Steen's study identified that women used sensory words such as 'sore, throbbing, aching, tender and stinging' to describe perineal pain from day one to five postpartum (2008:386). Some women described their perineal pain in terms of physical symptoms, such as 'swollen', 'puffy' and 'bruised', associated with the physiological healing process (Steen 2008:389-390). Metaphors were only used by a few mothers and included: 'needle pricking / pin pricking', 'odd twinge', 'like period pain', and finally 'a falling out feeling' (Steen 2008:391). The insights of this current study confirm the findings from Steen's study. However, (as a phenomenological study) this study extends these findings and elucidates thick rich descriptions. Insights from the current study concerning women's experiences of third degree tears similarly add to the literature concerning descriptions of the experience, the impact on walking and recovery time.

In the early motherhood study insights revealed that having an abdominal caesarean wound was generally not as painful as expected. However it was difficult to juggle medical attachments such as intravenous infusions and urinary catheters, and to have to rely on other people to help with showering or breastfeeding. These insights illustrate the existential of the lived 'body' (van Manen 1997).

Caesarean surgery is discussed in the literature concerning pain, mother satisfaction, and mother – baby relationships (Pairman et al. 2010; Fraser & Cooper 2009) and the insights of the early motherhood study echo these existing findings. There is however less information in the literature concerning women's experiences following caesarean surgery. For example, a qualitative study of women's accounts of recovery after caesarean birth revealed diverse physical health issues, including pain and reduced mobility, abdominal wound problems, infection, vaginal bleeding and urinary incontinence (Kealy et al. 2010). The early motherhood study, however, extends the understanding of this aspect of early motherhood. The insights of this study offer a fresh awareness of the challenges of grappling with new motherhood while recovering from major surgery.

In the current study a postpartum haemorrhage complicated almost half of the births in the cohort. For some women it involved an awareness of bleeding and the sensation of 'just bleeding and bleeding'. Others were only partly aware of what was happening but were alarmed by the serious and concerned looks on the faces of partners or midwifery staff around them. The incidence of postpartum haemorrhage ranges from 5 to 15 per cent of births worldwide and is defined as excessive blood loss (500 ml plus) after the birth and within the first 24 hours (Pairman et al. 2010). This indicates the small cohort in the early motherhood study seemed to experience a high level of postpartum haemorrhage. The literature identifies risk factors of postpartum haemorrhage as including atonic uterus, prolonged labour, induction or augmentation of labour and retained placenta (Fraser & Cooper 2009). The birthing outcomes and level of intervention received by the cohort in this study are consistent with these risk factors. While management and prevention of postpartum haemorrhage are discussed in the literature, women's experiences of postpartum haemorrhage do not seem to be addressed in the academic literature at all. The insights of this current study, therefore, extend understanding of women's experiences of this birthing complication.

A number of physiological changes were experienced by women postpartum, reflecting the existential of the lived 'body' (van Manen 1997). All women described dramatic changes in the fullness of their breasts as the milk 'came in', and generally described their abdomen as floppier and having a lot of loose skin. However women felt less restricted and lighter than when they were pregnant and found it easier to sleep comfortably. The amount of 'purpley-red stretch marks varied between participants and was seen by some women as the battle scars of pregnancy. The study insights concerning women's experiences of their breast milk 'coming in' highlighted a dramatic and significant experience. Women's breasts were depicted as ranging from just feeling heavy to feeling 'as hard as rocks'. Severely engorged breasts were described as red, swollen massive and excruciatingly painful. This insight confirms existing midwifery knowledge (Macdonald & Magill-Cuerden 2011, Pairman et al. 2010) but also extends this by offering vivid descriptions of what this actually felt like and enhances understanding of women's experiences of this aspect of early motherhood.

While a number of women had returned to their pre-pregnant weight by the eight week interview, they noticed that although their weight was reduced, their body shape was changed and just not the same as previously. The literature on bodily changes associated with early motherhood focuses on weight gain, postnatal exercises and maternal diet (Macdonald & Magill-Cuerden 2011; Walker & Freeland-Graves 1998). In addition, research exploring body image in the postnatal period has identified narratives relating to early motherhood and the part body image plays in women's experiences of this (Jordan, Capdevila & Johnson 2006). For instance, Jordan et al. (2006) found that while body image was a concern for many new mothers it was of variable importance and among a number of concerns. In contrast, research by Clarke et al. (2009) found that women had greater dissatisfaction with their bodies in the postpartum period compared to during pregnancy as women felt fatter and more concerned with their shape and weight postnatally. These insights of the current study confirm existing knowledge and add rich description of women's experience.

In the early motherhood study some women experienced intense stinging when voiding due to perineal trauma or anterior vaginal tears after a spontaneous vaginal birth. Most participants also described feeling anxious and hesitant about using their bowels for the first time after having their baby and some expressed concern about their perineum tearing or splitting open. In the early motherhood study women with indwelling urinary catheters following interventions, such as epidural analgesia or caesarean surgery, experienced these as restrictive, limiting them rolling to only one side and tying them to the bed. Others again experienced sudden urges to empty their bladder but suffered urinary incontinence and did not quite make it to the toilet.

The literature identifies urinary tract infection and urinary incontinence as possible complications in the postnatal period (Macdonald & Magill-Cuerden 2011) with the National Continence Program advising that one in three women who have ever given birth experience incontinence (Department of Health and Ageing 2011). While a lower incidence of incontinence was reported in the current study, this question was not directly asked of participants. In a similar vein, none of the cohort of the early motherhood study reported urinary tract infections, although some women with complicated births and interventions received prophylactic antibiotics to prevent uterine infections. Women's descriptions of bladder changes postnatally confirm existing

knowledge, however, there is nothing in the literature that describes the experience of women feeling restricted by a catheter. As a phenomenological study the current study insights offer new knowledge by adding detailed descriptions of women's experiences of being restricted by a catheter in the immediate postnatal period.

There are topics concerning women's physical experiences after childbirth that could be considered as being private or personal. For example, a women's physical experiences of using their bowels in the early days after childbirth. There is only minimal literature that addresses this topic, although it is a topic that causes anxiety and concern in new mothers. For example, Fraser & Cooper (2009) just comment that minor bowel disorders are common in the first few days after birth and women may need reassurance. The current study found that participants were very concerned and anxious about using their bowels in the immediate postnatal period. Some felt scared because of the memory of pushing their baby through the birth canal as it resembled the sensation of going to the toilet. Some felt that so much had gone on in their perineal area and that it was still so tender that they 'couldn't push there again'. The fear that they may tear again or split open was acute and foremost in many women's minds and they were consequently relieved to use their bowels without complication. These insights reveal women's intimate experiences with this aspect of early motherhood. The insights provide new knowledge and offer rich descriptions that will increase awareness for midwives and MCH nurses working with new mothers.

Physical tiredness affected almost all participants and was manifested as losing patience quickly, not being able to cope as well and feeling stressed. The tiredness of new motherhood was a continual kind of tiredness, where responsibility for a small baby meant that although they wanted to sleep they could not and which became a way of life. This illustrates the existential of the lived 'body' (van Manen 1997).

There is extensive literature around the topic of postpartum tiredness and fatigue (Hunter, Rychnovsky & Yount 2009; Runquist 2007; Lee, Lee, & Lee 2007; Troy 2003). Corwin and Arbour (2007) define postpartum fatigue as 'an unrelenting condition that affects physical and mental health.' (2007:215). These authors also reported that fatigue has implications for daily activities, social interactions and

enthusiasm. Physical factors contributing to postpartum fatigue include length of labour, extent of blood loss with birth, discomfort or pain and healing of a caesarean wound or episiotomy (Troy 2003). Other factors contributing to postpartum fatigue include depression, difficulty sleeping, lack of assistance with housework or childcare (Troy 2003). Runquist (2007) found in her grounded theory study that postpartum fatigue emerged as a very overwhelming and distressing experience that altered every aspect of participants' lives. The challenge for new mothers is that they have to manage having enough rest while looking after a new baby. The published literature on tiredness in the postnatal period supports the insights of the early motherhood study.

In summary the insights concerning women's physical experience of early motherhood during the postnatal period revealed in the current study have been discussed in terms of the literature. While it is not feasible to make statistical comparisons between this small qualitative study and data from the quantitative studies, the insights of this study offer rich and thick descriptions of women's experiences, deepening understanding for both other women and also midwives, MCH nurses and other health workers. The next theme to be discussed is that of women's experiences of learning to feed.

Learning to Feed

Learning to breastfeed was harder than women anticipated and all participants described some initial difficulties. The existential tenets of the lived 'body', lived 'space' and lived 'other' (van Manen 1997) were explored here. The women's particular birth experiences and associated complications and interventions sometimes compounded the difficulty of learning to breastfeed. Usually the first feed occurred in the labour ward supported by the midwife, but for some participants it was delayed until after transfer to the postnatal ward. Women experienced nipple pain to different degrees which was described as tender or very very sore. Having to cope with intravenous lines, urinary catheters, blood transfusions, surgical incisions, painful perineal sutures or passing large blood clots was sometimes overwhelming as women concurrently entertained visitors, manoeuvred a crying baby at their breast and learnt to breastfeed. Often women also struggled with conflicting advice. Support to breastfeed varied with some

women experiencing extensive help and a few describing intrusive rough intervention. In several situations family members such as mothers, sisters and husbands were a significant source of support for new mothers.

There is an extensive volume of literature concerning the issue of breastfeeding; however it is only focussed around several key areas. These areas include the benefits of breastfeeding (Abrahams & Labbock 2009; Australian Medical Association, 2007), teaching breastfeeding (Khresheh, Suhaimat, Jalamdeh & Barclay 2011; Kronborg, Damkjaer & Vaeth 2011) and managing breastfeeding problems (Scott, Robertson, Fitzpatrick, Knight & Mulholland 2008; van Veldhuizen-Staas 2007). There is literature emerging on women's experiences of breastfeeding, but it is somewhat less developed (Kelleher 2006; Manhire, Hagan & Floyd 2007; Schmied & Lupton 2001;Schmied & Barclay 1999; Harris, Nayda & Summers 2003). In developed countries there is evidence of a culture of women indicating they will 'try' to breastfeed, and will do it 'if they can' (Bailey, Pain & Aarvoid 2004). This section will discuss the literature concerning women's experience of learning to breastfeed. In particular the discussion will focus on the literature concerning women's first attempts at feeding, their physical experience of breastfeeding, the emotional experience of breastfeeding, conflicting advice and support to breastfeed, which were key issues in the current research.

First attempts at feeding

The World Health Organisation (WHO) and United Nations' Children's Emergency Fund (UNICEF) developed the ten steps to successful breastfeeding in 1991 to promote maternity services as being centres of breastfeeding support. There is an extensive amount of research providing an evidence base underpinning these strategies (WHO 1998). Helping mothers initiate breastfeeding within a half hour of birth, encouraging rooming in, breastfeeding on demand, showing mothers how to breastfeed and maintain lactation, having a breastfeeding policy that is communicated to all staff and training staff in the skills necessary to implement the policy are all pertinent to women's first attempts at feeding their baby (WHO 1998).

In the current study while most women reported initiating breastfeeding in the birthing room, almost one in four women reported not feeding their baby until 1.5 -7 hours after birth when they were back in the postnatal ward after a caesarean or assisted vaginal birth. This is contrary to the body of research that advocates supporting women to breastfeed within half an hour of birth (Puig & Sguassero 2007; WHO 1998). Women in the current study who were able to feed their newborns in the birthing room describe much satisfaction and sense of personal achievement and special joy with this first feed. This supports the findings by Manhire et al. (2007). The insights of the early motherhood study are supported in the literature, but highlight issues in following the WHO Code.

The physical experience of breastfeeding

Women's general physical discomfort postnatally was dependent on the degree of difficulty involved with the birth and the extent of intervention employed (McDonald & Magill-Cuerden 2011; Fraser & Cooper 2009). For example, caesarean surgery is a major operation and can impinge on a woman's ability to undertake early mothering tasks such as breastfeeding (Manhire et al. 2007). Likewise, women who have perineal trauma may find it difficult to sit down due to pain. These situations can impact on women's' physical experiences of learning to breastfeed. This was confirmed in the early motherhood study, with some intense descriptions of women's experiences enhancing the understanding of this.

A small volume of research has explored women's physical experiences of breastfeeding (Kelleher 2006; Manhire et al. 2007; Harris et al. 2003; Schmied & Barclay 1999). Physical pain and discomfort associated with breastfeeding and described in the literature include breast engorgement; cracked, bleeding or sore nipples; blisters, and uterine cramps. (Kelleher 2006; Manhire et al. 2007; Harris et al. 2003; Schmied & Barclay 1999). For example, research by Kelleher (2006) explored women's experiences of pain and discomfort associated with breastfeeding and found it ranged from mild temporary pain to more severe and at times unbearable pain. The extent, intensity and duration of breastfeeding difficulties surprised many women (Kelleher 2006). Schmied and Lupton (2001) add that some women experience

dissatisfaction and distress with the physical sensation of breastfeeding. The insights of the early motherhood study concerning breast and nipple pain were confirmed in the literature and the rich descriptions of participant's experiences extend and enhance understandings of this.

The Emotional Experience of Learning to Feed

Women's descriptions of learning to feed are often heavy with emotion as they grapple with breastfeeding difficulties, fatigue, anxiety, or unanticipated responsibility (Harris et al. 2003). Breastfeeding was reported to be much harder than anticipated and women's emotional and psychological states were linked to their physical conditions (Kelleher 2006). Furthermore, increased responsibility for the baby's wellbeing engenders nervousness and tension which contributes to the emotional experience of learning to feed (Harris et al. 2003). Many women are overwhelmed by the responsibility of breastfeeding (Kelleher 2006). This was confirmed in the current study.

Support and Conflicting Advice

The support of nurses, midwives and lactation consultants has been found to influence women's experiences of the physical aspects of breastfeeding in both positive and negative ways (Schmied, Beake, Sheehan, McCourt & Dykes. 2009; Forster & McLachlan 2010; Kelleher 2006). For some participants assistance with breastfeeding was integral to overcoming pain and discomfort, while for others the hands on management where the nurse or midwife physically grabbed a woman's breast and pinched the areola to manoeuvre the baby into latching on was intimidating and intrusive (Kelleher 2006; Deverell & Tuck 2004). Inconsistent and conflicting advice is also raised in the literature as causing confusion for mothers in how to attach their baby to their breast and other issues, such as positioning, milk supply and length or frequency of feeds (Walsh, Pincombe & Henderson 2011; Schmied et al. 2009; Hauck, Graham-Smith, McInerney & Kay 2011). The current study confirms existing knowledge regarding the physical experience of breastfeeding, the pain and discomfort of sore

nipples and difficulties associated with caesarean surgery. In addition, the current study confirms a silence about the negative aspects of breastfeeding and women's surprise at the difficulties encountered when breastfeeding. However the current study extends existing knowledge by revealing thick descriptions of breast and nipple pain and the awkwardness and complexity of juggling intravenous lines, abdominal wounds, urinary catheters, flat nipples and hungry or crying babies.

One of the challenges for new mothers is the transition from supported hospital care to being home and being responsible for a new baby. Learning to breastfeed is a process that occurs over time. **The first night home was dreaded by many participants. For some it was a nightmare with the baby constantly feeding, awake, unsettled or colicky and exhausted confused parents unsure of what to do next. Having a crying baby that could not be settled and only slept a few hours at a time was erroneously interpreted as not getting enough breast milk. Being unable to express milk with a breast pump used for the first time was often falsely thought to confirm the incorrect perception of low supply. At some stage breastfeeding was seen as being too hard, especially if women became overwhelmed by disturbed nights, frequent feeds and lack of time to look after themselves. Women described feeling guilty if their lactation failed or they decided to stop breastfeeding, and expressed self reproach about being a new mother and not knowing, or understanding an aspect of breastfeeding. In the early days after having a baby, breastfeeding was much harder than expected. These insights reflected the existential tenets of the lived 'body', lived 'other' and lived 'space' (van Manen 1997).**

This early struggle with breastfeeding is supported in the literature with support and encouragement for breastfeeding and mothering identified as being crucial (Manhire et al. 2006). Research by Hauck et al. (2002) found it important for women with breastfeeding difficulties to see signs of improvement. Other work by Cooke, Sheehan and Schmied. (2003) identified that breastfeeding problems in themselves did not predict early weaning, but that it was the mother's interpretation that influenced the outcome.

Going home with a new baby can also be challenging and anxiety laden for new mothers. It involves making the transition from hospital care to being at home,

understanding the intricacies of breastfeeding, infant settling and managing the baby's crying and one's own tiredness and becoming confident in the new role (Griffin 2010).

Having an unsettled or crying baby and being uncertain about breastfeeding has been reported as distressing to new parents (Deverell & Tuck 2004). Combined with tiredness or fatigue, as discussed earlier, it presents a difficult situation for new mothers. Unfortunately, crying or unsettled babies may be upset for various reasons, but it is often automatically assumed that they must be hungry. The concept of perceived insufficient milk is one of the most common reasons for women ceasing breastfeeding early. For example, research by Sacco, Caulfield, Gittleson & Martinez (2006) identified that women considered crying to be the main symptom of perceived insufficient milk. The insights of the current study indicate the need for more information and support regarding this issue.

The literature documents that breastfeeding can be seen as overwhelming and too hard (Hauck, Langton & Coyle 2002; Bailey, Pain, & Aarvold 2004). Women's guilt about not knowing aspects of breastfeeding or not continuing breastfeeding was also evident (Forster & McLachlan 2010; Griffin 2010). The insights of the early motherhood study confirm these, but also extend what is known about in the literature by adding vivid descriptions of participant's experiences and at times distress which enable deeper understandings of these experiences.

At the eight week interview participants had all settled in a method of feeding, although a few battled some ongoing lactation difficulties. Breastfeeding was viewed as significantly easier and women wondered if the improvement was due to the baby or their own increasing confidence. Those who had weaned spoke of greater freedom and an end to leaking breasts and cumbersome breast pads, but were satisfied their baby was gaining weight and was content. These insights reflect the existential tenets of the lived 'body' and lived 'other' (van Manen 1997). At this stage of early motherhood many women had settled into a pattern of feeding that was comfortable for them. Some women find bottle feeding easier and less stressful than breastfeeding. This may be due to breastfeeding problems, or because they can see what the baby is drinking (Bailey et al. 2004; Forster & McLachlan 2010). The

literature records a significant fall in breastfeeding rates between discharge from hospital (85.8 per cent) and three months after birth (60.5 per cent) (Amir et al. 2010).

Learning to Mother

The existential tenets of lived 'other' and lived 'body' (van Manen 1997) were interspersed throughout the insights of learning to mother. Learning to mother was a profound and intense experience with fluctuating emotions. Joy, wonder and pleasure were juxtaposed with feeling overwhelmed, not being able to cope and concerns about postnatal depression. There were many situations where participants did not really know what to do to manage issues such as infant crying or helping to settle their baby to sleep. Lack of knowledge was compromised further by uncertainty or confusion. Women were distressed themselves to hear their baby cry. Women had expected being a mother to be difficult, but experienced that it was much harder than expected. There was a clash between their expectations and the reality of caring for a newborn infant.

For new mothers, the early weeks after the birth are a time of excitement and joy, but also anxiety (Leahy-Warren & McCarthy 2011). Learning to mother is a profound and intense experience in the early motherhood period. During the early motherhood period participants experienced being a mother as much harder than expected. This was observed by Barclay et al. (1997) and Rogan et al. (1997) who used a grounded theory analysis to develop a new theory of early motherhood. They noted that women experienced significant losses and often felt overwhelmed and alone before developing a sense of themselves and a sense of synchronicity with the baby (Rogan et al. 1997). The insights identified in the current research are consistent with the work done by these researchers (Barclay et al. 1997; Rogan et al. 1997).

Women's views and experiences in regards to learning to mother have been explored in several other recent studies (Forster et al. 2008; Deave, Johnson & Ingram 2008; Perrson, Fridlund, Kuist & Dykes 2010; Young 2008). Forster et al., for example identified that new mothers had fears and anxieties about early parenting and their changing roles. Other research has confirmed that women wanted more information

about a range of issues relating to becoming a mother (Persson et al. 2010; Young 2008). These issues included preparation for breastfeeding, parenting and how to care for the baby (Deave et al. 2008; Persson et al. 2010; Young 2008).

The existential tenets of lived 'other' and lived 'body' (van Manen 1997) were illustrated in further insights. While women received information antenatally about labour, birth and pain relief there were perceived areas of gaps concerning early motherhood. These include emotional changes in the first week, passing blood clots and breastfeeding being painful or difficult for some. Gaps in information about infant care included normal newborn behaviour, feeding patterns, maintaining breast milk supply and settling strategies. Becoming a mother involved a shift from women just thinking about themselves and their partner to being responsible for a vulnerable new baby that they need to integrate into their life. For most everything now revolves around the baby. Women became more confident in their mothering as their understanding and experience increased and emotions settled.

Research from a Queensland study found that few women felt prepared for the experience of early motherhood or the common problems in the early months (Barnes et al. 2008). These authors report that current models of education and care may not address the needs of first time mothers (Barnes et al. 2008). Work by Rowe and Barnes (2006) indicates that both lay and expert knowledge may have a role in supporting women during early motherhood.

The need for consistent information that assists parents to feel more confident in caring for their baby was recommended by Persson et al. (2010). The literature notes that becoming a mother is a life changing event and involves a great sense of responsibility and emotional change and challenges (Deave et al. 2008; Keys 2007). There were significant clashes reported between women's expectations and the acute reality of their experiences of early motherhood (Griffin 2010, Miller 2007).

Two educational intervention programs to reduce anxiety, depression and parenting difficulties have been developed in Australia (Milgrom, Schembri, Ericksen, Ross & Gemmill 2011; Rowe & Fisher 2010). The intervention by Milgrom et al. (2011)

consisted of a self-guided work book and weekly telephone support to prepare women for the transition to parenting. In a randomised controlled trial this program demonstrated effectiveness as both a preparation for parenthood program and in reducing postnatal anxiety and depression (Milgrom et al. 2011). Similar goals underpinned the postnatal intervention devised by Rowe & Fisher (2010). Their program aimed to address the special learning needs of first time parents via a universal program. The needs of first time parents were conceptualised as skills to promote settled infant behaviours and communication within the couple relationship; both issues associated with postnatal depression and anxiety (Rowe & Fisher). These risk factors were addressed in a half day seminar targeting first time parents with 4 week old infants in universal primary care settings (Rowe & Fisher 2010). These empirically evaluated programs appear useful and pertinent, but the challenge or dilemma is having these integrated into universal maternal, child and family health programs and widely available to new mothers and their families.

The insights of the early motherhood study are confirmed in the literature concerning the theme of learning to mother. The thick descriptions of women's experiences add a rawness and heighten awareness of women's level of distress experienced from situations such as having a persistently crying baby or 'not knowing' how to soothe or care for an upset baby and the fact that being a mother was much harder than expected. The early motherhood study insights concerning learning to mother add extra detail and extend current knowledge in the literature.

Relationships

Women's experiences of their relationships in the early motherhood period were explored in this current study in terms of their relationships with their partner, their infant, their own mother and their extended family, friends and community members. This section of this chapter will discuss the key insights from this research concerning women's lived experiences of these relationships in terms of the literature.

Relationship with Partner

Living the tensions of the changing nature of relationship was a core theme underpinning women's interaction with their partner in the early motherhood period. The birth of their first child was a profound and life changing event. Having a baby was generally perceived as bringing a woman and her partner closer together as a couple. The baby was also seen as 'something that they had created together' generating a bond the woman would always share with her partner. For most participants their partner was their main source of support during the early motherhood period. This highlights the existential tenet of lived 'other' (van Manen 1997).These insights concerning early parenthood being a major life transition and couple relationships involving much change at this time are documented fairly extensively in the literature (Griffin 2010; Deave et al. 2008; Osborne 2006). Tensions in couples' relationships as women grappled with change are also identified by Garvan (2010) in her doctoral thesis.

At the same time, this current study found that tiredness and lack of sleep brought increasing irritability and crankiness to many of the women's relationship with their partners and couples were more likely to snap at each other. Similarly, much of the literature documents a decline in partner relationships across the transition to parenthood (Lawrence, Nylen & Cobb 2007; Lawrence, Rothman, Cobb, Rothman & Bradbury 2008; Petch & Halford 2008). However, whereas published studies tend to encompass longer time periods (the first 3, 4, 6 or 12 months after childbirth), the research presented in this current study concentrated on the initial 8 weeks after women gave birth and possibly presented a slightly rosier perspective as some relationship difficulties may not yet have emerged. **In this early motherhood study levels of tension varied between couples but reached the point of conflict for some.** This diversity of experience reflects the range of situations that women lived their lives and is consistent with other findings (Griffin, 2010; Garvan 2010; Osborne 2006). Randomised controlled trials of brief education programs to enhance couple relationships across the transition to parenting and assist new parents with parenting are beginning to be reported in the literature (Halford, Petch & Creedy 2010; Petch & Halford 2008).

The current research found that sharing the load of household chores and parenting had diverse meanings for different couples and was problematic in some relationships. Expectations and responsibility for housework were renegotiated by some couples for tasks such as vacuuming, cooking and washing dishes. Asking for help was an issue for some participants, particularly if they were not used to it; and women said it was often easier for them to 'just do it' themselves than ask for help. These insights were confirmed in Garvan's research (2010:178-181) and also literature on relationships (Osborne, 2006; and Griffin 2010). The uniqueness of the current research is that the phenomenological approach elicits rich descriptions of women's experiences of these matters.

The early motherhood study found that active sharing of parenting roles varied; a few fathers with formula fed infants took turns with the night feeds while they were on paternity leave or gave the weekend night feeds. Some fathers of breastfed infants shared the parenting by getting the baby up or changing their nappy when they woke for a night feed and taking him or her to his partner to breastfeed. This is consistent with the literature in that some new mothers are supported with night time feeding and parenting while others are not (Le Blanc 1999).

Mothers who did receive support with parenting described the assistance as very helpful and appreciated the extra sleep or rest at those times. Difficulties and struggles in women's relationships with their partners described in the literature include tiredness, exhaustion, tensions about sharing the workload, social isolation and frustration (Barclay et al. 1997; Darvill, Skirton & Ferrand 2008; Osborne 2006). These confirm the insights of the current study. **When partners returned to work women generally elected to assume responsibility for night time parenting, concerned about the safety of their partners working with heavy machinery or driving to and from work without adequate sleep.** This insight has not been identified in the literature although it is consistent with anecdotal information and practice. It is a problematic situation in that it implies that it does not matter if the mother misses sleep as she does not need to be functioning well to care for a young baby. Caring for a young baby can be physically and emotionally draining, and enabling both parents to be functioning at their best contributes to children's wellbeing and safety.

The current study revealed that conflict occurred in relationships when participants interfered with their partner's care of the baby. Allowing their partners space and time to work parenting out for themselves was challenging for some participants. Another area of tension concerned the inequitable sharing of personal 'self' time. Some women were angered and frustrated when they could only snatch moments of time for themselves while their partners engaged in their usual recreational activities. At times other dilemmas surfaced such as a participant's partner being ill, and she was suffering the quandary of yearning to care for her partner but choosing to care for their baby as they were helpless.

Women and men take on their roles as parents differently. Fathers need some time and space to become comfortable caring for their baby and can feel resentful of being given instructions or being supervised as they take on the caring role (Osborne 2006). Mothers have often had extra time to practise parenting skills and can feel uncomfortable allowing their partners to learn in their own time in their eagerness to have everything attended 'properly'. Having the first child come in to the family is seen as potentially precipitating relationship issues (Corney & Simons 2004). The literature notes that tensions, conflicts and challenges concerning parenting techniques, and unequal personal 'self time' may arise (Griffin 2010; Osborne 2006).

Insights from the current study revealed that maintaining intimacy in their couple relationship was challenging for many participants. Preserving a close adult relationship required effort and creativity as intimacy was affected by the birthing experience, perineal injury, exhaustion, sleeping in separate rooms, shift work and the extent of support in the home. These situations added a heightened level of frustration to the relationship. They also reflect the interrelated nature of the existential tenets of lived 'body', 'time', 'space' and 'other' (van Manen 1997). These insights are confirmed in the literature which highlights that birthing experience (Rogers, Borders, Leeman & Albers 2009), fatigue (Medina, Lederhos & Lillis (2009), role overload (Lachance-Grzela & Bouchard 2009; Nystrom & Ohrling 2004), stress (Randall A. & Bodenmann 2009, Nystrom & Ohrling 2004), and perceptions of unfairness in family work can impact on the couple relationship (Grote, Clark & Moore 2004; Grote & Clark 2001). For instance, Ahlborg, Dahlof and Hallberg's (2005:167)

grounded theory study of first time parents intimate relationships found that while most parents were happy in their relationship both parents were dissatisfied with their sexual relationship and that 'being too tired for sexual activity' was difficult. The current study adds to the existing literature by synthesising women's stories of lived experiences in regards to these aspects of relationships.

At the same time, the focus of women's relationships generally shifted to their baby and his or her care needs, and participants found it was hard to have time for themselves as a couple. The shift of focus to the baby has been reported in the literature (Ahlborg & Strandmark 2001). This research by Ahlborg and Strandmark explored the intimate relationships of first time parents through individual interviews when the baby was six months and 18 months old respectively. The essence of the phenomenon revealed was that 'the baby was the focus of attention' (Ahlborg & Strandmark 2001:318). This finding had different meaning to different couples: for one group the baby was the subject of mutual concern. For the second group, the baby was focussed upon but this was at the expense of the father who felt excluded emotionally. This adversely impacted on the couple relationship and parenting (Ahlborg & Strandmark 2001).

In the current study participants who raised the topic of sexual relationships generally shared that these were sometimes deferred for some months due to medical conditions in late pregnancy such as pre-eclampsia and postponed after birth due to perineal trauma or caesarean birth. Sexual activity was seen as facilitating intimacy and a bond in relationships. The literature around this topic confirms this insight. Recovery from birth trauma or surgical delivery delays return to sexual activity for many women with the subsequent strain on the couple relationship. In one study 32 per cent of women had resumed sexual intercourse six weeks after birth and 81 per cent had resumed intercourse three months after birth (Barrett et al. 2000).

Although the notion of becoming a family was celebrated in the immediate period after birth, this concept waned across the postnatal period. While the family had been created in a biological sense, in an emotional sense this was still in progress, as most participants were preoccupied with the multitude of tasks involved in physical recovery from the birth, learning to feed and mother their baby,

renegotiating the relationship with their partner and interacting with family and friends. This situation is documented in the transition to parenthood literature (Nelson 2003; Miller 2005). The development of the family is considered to occur in stages (Duvall and Miller 1990) with the stage of early childbearing extending from the birth of the first child until that child is about three years old. Tasks for this stage of family formation include integrating the infant into the family, accommodating new parenting roles and maintenance of the couple relationship (Duvall & Miller 1990). The current research suggests that the integration of the baby into the family and parenting roles had priority over preserving the couple relationship in the early motherhood period explored in this study.

Mother-Infant Relationship

The majority of participants in the study described being overwhelmed with love for their baby from the beginning: seeing their baby as being warm, beautiful, trusting, melting their hearts and loving them to tears. They did not want anything bad to happen to their baby ever, and felt protective of them from birth. Time was spent every day just watching or holding their baby, studying their features and movements and feeling a joyful delight and pride. Almost half of participants experienced bonding with their baby as a relationship that developed gradually, rather than being instantaneous. This reflects the existential tenets of lived 'other', and 'time' (van Manen 1997).

There is an extensive literature concerning mother-infant relationships. The term attachment was first used in the eighteenth century in relation to mother-infant relationships by Rousseau whose writings concerned maternal love (Goulet, Bell, Tribble, Paul & Lang 1998). The establishment of a parent-child relationship is very important for the future emotional development of the child (Mares et al. 2011). Much research on attachment focuses on infant to parent attachment. Bonding between mother and infant has been studied for over 40 years (Schenk, Kelley & Schenk 2005). Research by Klaus and Kennel identified bonding as 'a unique relationship between two people that is specific and endures over time' (1976:2). They considered bonding to be an event and hypothesised that prolonged contact between a mother and her newborn

baby immediately after birth was critical to establishing this. Many subsequent studies that have attempted to validate Klaus and Kennel's work have been limited by flaws in concepts or methodology (Svejda, Campos & Emde 1980; Goldberg 1983) or have had inconsistent conclusions (Brown & Hellings 1988).

Recent research has identified that there is a neurobiological component to attachment (Barrett & Fleming 2010; Swain, Lorberbaum, Kose & Strathearn 2007). Brain mechanisms involved in regulating mothering behaviour have been identified as the hypothalamus, the limbic system and the cortex (Barrett & Fleming 2010). Other recent research by McConnaughy (2010) explored mothers' perceptions of their bonding process with their first children. Similar to the current study this qualitative research found that about half of the mothers reported they bonded with their babies immediately after birth, or bonded during pregnancy. The other half of the mothers reported that their bonding experience was gradual over the first two years. Most participants considered there was a point in time when they recognised they were "fully bonded" to their child (McConnaughy 2010). The insights of the current research concerning mother-baby relationships confirm this aspect of the literature and also add rich descriptions of this aspect of lived experience.

In the current study the situations where slower bonding occurred varies, as did the individual context of birth. For example some mothers experienced traumatic or complicated births and were exhausted or unwell after labour was completed. Infants sometimes had bruised and battered faces and were irritable for several days. In these situations some mothers described not really feeling a connection with their baby during the hospital stay. As women began to feel better and overcome health or breastfeeding issues they were able to enjoy their baby more, gradually establishing a warm relationship and connection with their infant in the weeks after they were at home.

Previous research has identified a range of factors than may contribute to delays in mother-infant bonding (Pairman et al. 2010; Fraser & Cooper 2009). Glasser (2007) found that there were differences in maternal-infant attachment based on type of delivery at one week after birth, although these were not present at six weeks after birth. Mother-infant interactions are adversely affected by issues such as prematurity,

prolonged labour, analgesia and anaesthesia, birth trauma or postnatal depression (Macdonald & Magill-Cuerden 2011; Mares et al. 2011). The research literature also discusses factors that have been shown to promote mother-infant bonding. These include midwifery practices such as minimal intervention during birthing, skin to skin contact immediately after birth for at least on hour, breastfeeding, rooming in and infant massage (Byrom, Edwards & Bick 2010; Smith 2010). The Australian Association for Infant Mental Health advises that from birth infants use facial expressions, vocalisations and body language to convey their feelings and communicate what they need (2006). When carers interpret these cues and respond with promptness and empathy babies feel secure (Australian Association for Infant Mental Health, Inc. 2006).

The current study revealed that new relationships take a little while to develop and that when baby cues were missed or misunderstood some participants became confused or overwhelmed. Inherent in participants' descriptions was that it takes time to understand what a baby needs and to learn to read his or her cues such as wanting to be cuddled, being tired or wanting space. Although many participants initially found it hard to understand their baby's cries, over a period of weeks most began to recognise and comprehend some particular cries. For these participants learning about their infant's behaviour and temperament was exciting and mothers' interactions with their babies were affirmed by responsive feedback from their child. Smiles, coo-cooey noises, vocalisations, eye contact with feeding, noiseless giggles and settling to sleep all reassured mothers that their relationship with their baby was developing and they were 'doing something right'.

Maternal sensitivity has been explored as a concept analysis (Shin, Park, Ryu, & Seomum 2008). Shin et al. (2008) contend that maternal sensitivity is important as it assists mothers in identifying infant cues and understanding infant communications. White, Simon & Bryon (2002) argue that information about infant states, infant cues and behaviours should be incorporated into antenatal education to help parents understand infant communications. The current research supports the literature in the insight that recognising infant cries and interpreting baby communications were steps to building and developing a relationship with their baby. Women's lived experiences of initially struggling to recognise and understand infant communications extend the current level of knowledge about this issue.

Relationship with Own Mother

Most participants in the early motherhood study described having a supportive relationship with their own mother, receiving emotional support, help with breastfeeding and settling and practical assistance with housework and meals in the post natal period. A review of the literature reveals only a small body of published work around the topic of the mother-daughter relationship and the daughter's transition to motherhood. The literature does not record much concerning the support that women receive from their own mothers, although it is known anecdotally. Doctoral work by Korn (2001) employed quantitative survey research using *The Family of Origin Scale* and *The Intimacy Scale* to explore changes in mother-daughter relationships after daughters became mothers themselves. Korn reported daughters having more in common with their mothers after they became mothers, being able to relate to them and understand their perspective better, having more respect and appreciation for their mothers and valuing their judgement more (2001). In a similar vein, a mixed methods study by Fischer found that when a woman becomes a mother that the mother and daughter tend to re-appraise each other and become more involved in each other's lives (Fischer 1983). Changes in the relationship between new mothers and their own mothers involve redefining and renegotiation of their respective social positions, roles and family structure (Fischer 1983).

The current study also found many women discovered a new understanding of what their mother had experienced in giving birth to them. For these women it was important to have their mother around. This insight is also supported by research by Fischer who found that daughters can become closer to their own mothers after having their own children as assuming a similar role gave them increased understanding of their mother's perspective and a fresh appreciation for their mother (1983). Friday (1979) writes about women having increased empathy with their own mother when they have children of their own. In a similar vein, Kitzinger reasoned that becoming a mother enables a woman to appreciate and understand her own mother in a different way (1993). The insights of the current study are consistent with the literature.

The current research found that even study participants who depicted relationships with their mother as 'not close' described increased contact with their mothers during the early weeks of after giving birth. A few study participants experienced their own mother as intrusive with visiting too often or too long. No study specifically addressing these issues was identified during the literature search although this is consistent with anecdotal information. Mother-daughter conflict is however documented in first-hand accounts of women's experiences such as Chesler's diary of motherhood (1979). This published diary describes an intensely conflictual and ambivalent relationship between Phyllis Chesler and her intrusive mother (Chesler 1979). Chesler and her mother have different opinions over a number of matters. The conflicting nature of their relationship is illustrated in one situation where Chesler's mother reminds her about sending out thankyou notes for baby presents. Chesler asks her mother to thank her friends for her and the interaction escalates to an altercation at screaming level. Issues at the essence of their relationship include Chesler seeking support from her mother and her mother expecting Chesler to adopt her mother's perspective of maternal responsibilities. Chesler's mother treats Chesler as a wilful child and simultaneously either chooses to withhold support from her daughter or is emotionally unavailable to provide this support.

> *... I fought with my mother. ... I am flooded with emptiness. My mother's not comfortable with me. (I'm not comfortable with her.) She's so terrified of being rejected by me (and I by her) that she rejects first. (She must be angrier than I am,) ... My mother will 'hate' me as long as I am not like her. As long as I expect her to mother me.* (Chesler 1979:93).

Ambivalence between new mothers and their own mothers seem to be mostly described in literature and anthologies written by women about birth and experiences of motherhood. For example, Woolfe (1996) depicts the relationship between a new mother and her own mother as characterised by communication difficulties, disappointments, and the new mother's yearning for her mother's understanding. This theme recurs in other short stories and accounts of women's experiences of early motherhood (Adelaide 1996). The early motherhood study insights are consistent with the literature in this regard,

Some participants in the current study had mothers who were absent due to death or living interstate or overseas. The absence of their mother during the transition to motherhood was experienced by a number of participants as difficult and exacting because the personal conversations, comfort and support from their mum were seen as unique and special and greatly missed. This was observed in Fischer's research, where it was also noted that geographic separation is perceived by daughters and their mothers as a greater problem once the daughter has a child (Fischer 1983). This information concerning absent mothers was not directly or indirectly located in any other academic study during the literature search and appears to be an area for further research.

So women's relationships with their own mothers can be complex. Relationships can range from those that are intensely helpful and supportive, discerning new understandings of their own mother, to more conflictual, difficult and exacting relationships due to missing mothers who have died or are separated by distance.

Conclusion

This chapter has discussed the insights of the early motherhood study in terms of the literature. Most significantly, this early motherhood study has also contributed new knowledge to what is known about women's experiences of early motherhood. This was revealed as women shared their lived experiences and will enhance understanding about the phenomenon of early motherhood. These are listed here:

Study Insights that Provide New Knowledge

- Women interacting with their foetus-playing games or having soothing communication to settle their not-yet-born baby,
- Women were surprised by the amount of blood accompanying childbirth,
- Women felt anxious and hesitant about using their bowels for the first time after having a baby, with some expressing concern about their perineum tearing or splitting open.

A number of the insights confirm what is already known as existing knowledge. These have been identified in this chapter and include issues such as pregnancy beginning a number of changes in women's lives, attentive concern and comfort from a partner or support person creating a safe place for women to labour, and breastfeeding sometimes seen as overwhelming or too hard.

Other insights revealed by this study have built on or extended existing knowledge about women's experiences of early motherhood. This was often due to rich, thick descriptions revealed in women's narratives, and which give voice to women's experiences and enhance understanding. These are listed here:

Study Insights that Build On or Extend Current Knowledge

Pregnancy

- Physical experience of pregnancy including changes in breasts, swelling abdomen, various intensities of morning sickness.
- Fluctuating and heightened emotions.
- Women's relationship with their foetus – conversation and touching of 'bump'.
- Contemplation, reflection and joy in preparing a place at home for the anticipated baby.
- Women holding so many questions in their minds as their pregnancies progressed. Some were musings and wonderings; some were more concerns or anxieties.

Labour and Birth

- Confusion and uncertainty pervaded the experience of recognising labour.

- Collection of women's descriptions of uterine contractions.
- Collection of women's descriptions of their experience of their waters breaking spontaneously.
- Strong labour being an arduous and physical experience that impacted on the whole body.
- Women described an altered consciousness and reduced physical mobility late in labour.
- Women required concentrated effort to endure powerful contractions and labouriously push the baby down the birth canal.
- Women's experience of their first meeting with their newborn baby ranged from wonder and elation to dazed exhaustion.
- The use of medical technologies and interventions restricted women's movements and access to comfort measures during labour.
- Women having a caesarean birth under epidural/spinal anaesthesia did not experience pain but were aware of pushing, pulling and their body jerking around during the surgery.
- Women felt frustrated with the physical limitations and slower recovery associated with a caesarean birth.
- Women were very fearful of epidurals antenatally due to concerns about potential complications such as paralysis, but found epidurals to be effective pain relief during labour.

Postnatal

- Women's perineal wounds were described as very painful, swollen and bruised. Those with third degree perineal tears experienced significant pain and discomfort that persisted for many weeks.
- Caesarean wounds were not as painful as women expected, however it was difficult to juggle attachments such as intravenous infusions and urinary catheters and to rely on people to help with showering and breastfeeding.
- Women's experiences of postpartum haemorrhage are described from their perspective.

- When women's milk 'comes in' their breasts ranged from feeling heavy to feeling 'as hard as rocks'.
- Women felt their movement was restricted by having a urinary catheter insitu following an instrumental, traumatic or caesarean birth.
- All women expressed initial difficulties breastfeeding and found breastfeeding to harder than anticipated.
- Coping with intravenous lines, urinary catheters, perineal or caesarean wounds was sometimes overwhelming as women concurrently entertained visitors, manoeuvred crying babies at the breast and learnt to breastfeed.
- Women struggled with conflicting advice, especially regarding breastfeeding.
- Family members such as partners, mothers and sisters were a significant source of support for new mothers learning to breastfeed.
- Women encountered gaps in information about both their own health after having a baby and also how to care for a baby.
- Maintaining intimacy in their couple relationship was challenging for some participants. Intimacy was affected by women's birthing experience, perineal injury, exhaustion and separate sleeping arrangements and extent of supporting the home.
- While the majority of participants described being overwhelmed with love for their baby from the beginning, almost half expressed bonding with their baby as a relationship that developed gradually rather than being instantaneous.
- In the early weeks of after childbirth women generally struggled to recognise and understand infant communications and cries, but these eventually became steps to building and developing a relationship with their baby.
- Women had expected being a mother to difficult, but experienced it as much harder than expected. They were not adequately prepared for early motherhood.

This chapter has discussed the study insights concerning early motherhood and identified those that represent new knowledge, those that confirm existing knowledge and those that extend current knowledge. The next chapter explores the researcher's reflections concerning the research experience (chapter 9). The final chapter (10) concludes the thesis.

Chapter 9
The Researcher's Journey into Phenomenological Inquiry

Introduction

The study insights regarding women's experiences of early motherhood were discussed in the previous chapter and considered in terms of the literature. Some of the insights confirmed existing knowledge, some added to existing knowledge and some contribute new knowledge. In this chapter the focus will shift to reviewing the researcher's journey with this study. As this chapter explores the researcher's personal reflections, it will be written in the first person. It will reflect on key learning associated with the research process through considering the major phases and themes of the project: deciding on a topic and methodology; getting the project details right; recruiting and retaining participants; built in support; engaging with information gathering; struggling to find what is normal; academic, peer and professional support; the challenge of writing and rewriting; and the influence of phenomenology on my practice.

Deciding on a Topic and Methodology

Deciding on my thesis topic was a protracted process indeed. It involved reflecting on my experience as a midwife and my practice as a maternal and child health nurse, considering my own previous research on women's experiences of motherhood and postnatal depression (see Sheeran 1997) and contemplation on my experience as a mother myself. It also involved many discussions with my supervisors. My interest was focused on mothers from the beginning, but danced around different aspects of the new motherhood experience: becoming a mother, maternal identity, making sense of motherhood, and the spoken-unspoken aspects of motherhood. A common thread coursing through the various possible topics was telling women's stories, giving a voice to women's experiences and exploring women's own perspectives of their experiences. Eventually I settled on the topic of exploring women's experiences of early motherhood.

As alluded to in chapter 3, a number of musings and deliberations, as well as discussions with my supervisors, preceded my final decision about a theoretical framework. Phenomenology as an approach was congruent with my research question of exploring the lived world of pregnant and new mothers. There were several phenomenological approaches to consider but I ultimately selected van Manen's hermeneutic phenomenology over other perspectives because of its focus on embodiment, which is pivotal to the pregnancy and childbirth experience. van Manen's four existentials of lived time, lived space, lived body and lived other have been valuable in exploring and reflecting on women's lived experiences of early motherhood (van Manen 1997). They have facilitated rich descriptions of women's physical, emotional, social and temporal experiences of late pregnancy and early motherhood as described in the three insights chapters (chapters 5. 6 and 7).

Getting the Project Details Right and Staying Focused

Completing the application for ethics approval from the university was a complex and daunting task. The final document totalled 39 pages and was a demanding and challenging process to complete. It was also an extremely useful process to undergo as it required careful review and clarification of each aspect of the research design and consideration and development of contingencies to address an array of situations. As such the ethics procedure guided the refinement of the research study. It was important in terms of the integrity of the study and also my personal integrity. The opportunity to refer even minor questions back to the Ethics Committee for guidance enhanced the transparency of the study and continuing to keep the ethics committee up to date with changes as they developed also maintained the rigour of the study. Overall the research design was enhanced by the meticulous requirements of the ethics application procedure.

Completing the research progress reports for the university higher degree committee was similarly a very useful process. It formalised a periodic review of progress at each six month stage and facilitated reflection and evaluation of the project. Periodically standing back and considering what had been achieved and what remained to be completed was a thoroughly helpful exercise.

Recruiting and Retaining Participants

Recruitment of participants was an unexpected major obstacle encountered in the study. The original strategy of inviting first time expectant mothers to participate via posters and flyers located at local medical centres and hospital antenatal clinics and from invitation by midwives was very slow and inefficient. After three months only three women had expressed interest in participating in the study. I was worried that I would not be able to engage enough participants and had used more than half of the long service leave that I had taken to recruit and interview participants. Discussions with my supervisors and the local hospitals resulted in permission to visit antenatal clinics and education classes personally to invite women to participate. This approach was much more successful. While it is mere speculation, I attribute this to participants being able to meet and assess the researcher face-to-face and decide if they would feel comfortable enough to spend an hour talking about their experience of early motherhood. While the promotional posters and pamphlets provided information about the project, discussing any questions or concerns in person seemed to reduce barriers to participation. Furthermore, introducing myself as a local midwife and MCH nurse seemed to be well received, whereas I feel that introducing myself as a university research student would not have worked as well and may have been construed as more distant or clinical. Interestingly, as first time expectant mothers most antenatal clients were not aware of the role of maternal and child health nurses.

Potential participants who were approached around full term appeared more reluctant to participate in the study, whereas women approached early in their third trimester seemed more comfortable about participating. While this phenomenon could comprise another research project in itself, I wonder if it is part of the psychology of late pregnancy, which tends to see women withdrawing inwardly to deal with anxieties or uncertainties as birth approaches.

The difficulty in recruiting participants added importance to retaining those participants who had agreed to be involved. This was particularly true in a longitudinal study that had interviews at key periods extending from 34 weeks gestation to 8 weeks after the birth, a period of three to four months during a challenging stage of life. I also felt a

genuine obligation to promote and maintain communication about the project with stakeholders such as participating agencies and participants. This was achieved by the publication of a series of nine newsletters between 2005 and 2009 see Appendix 11. The content of the newsletters evolved with the project and included an overview of the project, progress reports, and tips on journal writing and dealing with the vicissitudes of early motherhood. Acknowledgement of the role of participants and supporting agencies in the project was emphasised. Feedback from participants and stakeholders about the newsletters has been positive and the communication seemed to maintain momentum and interest.

Additional communication with participants involved 'thank you' cards sent after each interview, and a 'thank you' letter and card sent at the completion of the final interview. I considered this to be an important component of acknowledging the time and commitment participants gave to the project. It was a priority to show consideration and respect for participants, to use attentive and sensitive interview skills, and value participants' voluntary participation. This is a core part of ethical practice, but is also pivotal in woman-centred practice. I believe it was crucial to retaining participants as it nurtured relationships and acknowledged and valued the contribution of participants. All participants who commenced the series of interviews completed the full program of interviews at three key stages of early motherhood.

One difficulty with retaining participants involved the loss of pregnant women recruited to the study who developed pre-eclampsia or hypertension in the period between being recruited as participants with essentially healthy pregnancies and commencing the initial interview. These women were excluded as they were now potentially at risk. At the time I found this disappointing and frustrating. I was concerned about not having sufficient participants for the study and was also aware that those excluded progressed to have healthy term babies. After the exclusion of several volunteers in this category, application was made to the University Human Research Ethics Committee (HREC). The application involved an amendment allowing participants with medically managed hypertension or pre-eclampsia that developed after the initial interview to continue in the study provided mother and baby did not have an adverse outcome, such as requiring intensive care, or being separated from each other after birth. A total of five participants were treated with rest, medication, or induction of labour for pre-eclampsia or

pregnancy induced hypertension and continued in the study without adverse outcome, as defined above.

Built-in Support

A major strength of the study was the level of supports built-in for participants as expectant and new mothers. These included a list of 'Resources for Mums' which was distributed at the first interview. This resource provided contact details for a range of independent support services including 24 hour and local counselling and general health or parenting support services. This resource was initially developed by Women's Health Goulburn North-East and was revised and distributed by the Mitchell Maternal and Child Health Service (See Appendix 12).

Other supports built in to the project included the option for participants to contact the researcher to discuss their experiences between interviews and the allocation of a separate independent primary maternal and child health nurse for each participant. These strategies ensured ongoing researcher support available at the participant's choosing and ongoing independent nursing support for the family. I considered both these options to be important in caring for the emotional needs of participants.

The focus on participants' needs continued into decision making about the location of interviews. As participants were expectant and new mothers interviews were held at a venue chosen by the participant, with the understanding that the arrangements could be changed if the participant was tired or had an unsettled baby. Accordingly most participants chose to be interviewed in their own homes. There was a noticeable transformation in households from the quiet and peaceful atmosphere of most initial interviews in the antenatal period to the busier, sometimes outright chaotic atmosphere of the postnatal interviews. The presence of the baby was clearly broadcast by the prams, rockers, bassinets, change tables, nappy bags, breast pumps, baby's bottles, jumpsuits and bibs that invaded the home postnatally. The needs of the baby took priority over the interview process and the interviews were sometimes paused to allow mothers to pick up, feed or settle their baby. Women's experiences of early motherhood were observed and in a small way experienced by myself as 'everything' revolved

around the baby. As a researcher this was more demanding mentally and physically than a formal interview in an office environment, but the richness of the interview experience was enhanced by sharing these moments of women's lived experiences and 'being with woman'. I felt privileged to be able to nurse a crying baby while a mother went to the toilet prior to breastfeeding, or prepared a feed, or to pause the tape recorder while she took time out to soothe or resettle her infant. I think conducting the interviews in the natural setting also captured a little of the experience of phenomenology in action: a brief insight into the lived world of new mothers, valuing the uniqueness of the individual and being respectful of participants.

Engaging with Information Gathering

Working with the unknown was a challenge at times. My experiences along the field work journey enriched and informed the process of gathering information. The early stages were a steep learning curve, but I usually learnt quickly from my experiences and didn't make the same mistakes twice. Although I tried to be meticulous in setting things up as best I could, there were a couple of situations where I was caught out. The first situation involved my mini tape recorder jamming during an interview. I paused it while a participant attended to her baby, but could not get it to resume recording when the interview recommenced. I took written notes and clarified and recorded additional details at the subsequent interview, but it was an embarrassing situation that I naively did not expect. In subsequent interviews I always took a spare tape recorder in addition to the spare batteries I had always carried.

Another awkward incident was the first time a participant cried. It was an antenatal interview and the participant had been describing how she was emotional throughout her pregnancy. When I probed to explore what she meant by being emotional she described feeling overwhelmed at times and began to cry. It unfolded that she had recently moved from another part of Australia and both her and her partner's extended families were living long distances away in another state, and she missed her family. At the time I paused the interview while the expectant mother regained her composure. With her consent to continue I quietly moved the conversation to less sensitive topics. At a later stage I gently followed up her thoughts about her pregnancy and missing her

family and concluded the interview. Afterwards I stayed and chatted for a short period, ensuring she was feeling comfortable and no longer distressed.

I was surprised by my own reaction to this situation. I felt awful that I had caused a volunteer participant in the research to become upset and cry. In my work situation I often encountered clients who cried, and was generally quite comfortable dealing with them. In the research situation it seemed different as I was working with women who were kindly volunteering to give their time and share their experiences. I felt uncomfortable that I had caused distress that she perhaps would not have felt unless I was interviewing her. I had a long discussion about the situation with my supervisors and it was concluded that I had responded appropriately but that this kind of situation was perhaps to be expected given the exploratory nature of my topic. My supervisors pointed out that expectant and new mothers will feel emotional at times, but that sharing their feelings can in fact be therapeutic. I nonetheless still felt reticent to have any participants become distressed during the interviews, but felt reassured to continue. However the basket I carried with my note book and tape recorders for fieldwork now had a box of tissues added to it.

Struggling to Find What is 'Normal'

A major difficulty in this study was determining 'normal' in terms of a normal pregnancy and birth. The dilemma centred on distinguishing what is normal from what is usual. Within contemporary practice intervention which is usual or common- place seemed to be considered 'normal'.

This issue was referred to earlier in this chapter in terms of accessing sufficient participants with a 'normal pregnancy', where approval was sought from the HREC to allow participants with medically managed pre-eclampsia or hypertension to continue in the study provided they did not have adverse outcomes. While most study participants were in good health and experiencing a healthy normal pregnancy, five participants did receive some medical management for pre-eclampsia or hypertension late in their pregnancies. As participants approached full term or commenced labour, medical involvement lead to interventions that seemed to have a cascade effect, releasing a

stream of further interventions to manage complications. Contemporary practice demonstrates a lack of confidence in the ability of women to birth naturally, or at the very least a philosophy of intervening to avoid possible complications on a 'just in case' basis. It was disheartening at times to hear women describing inductions of labour, prolonged labours, instrumental deliveries, postpartum haemorrhages, and third degree vaginal tears in such a small cohort of participants. Interestingly, it has been observed that in contemporary maternity practice 'normal' is only defined retrospectively (Cherniak & Fisher 2008; Werkmeister et al. 2008). There is some sense of normal midwifery care being substituted by institutionalised, mechanised obstetric care. This epitomises the challenge confronting midwifery and obstetric practice. However, in this research study participants were grateful to have a healthy baby.

Academic, Peer, and Professional Support for the Research Journey

Academic, peer and professional support helped considerably in maintaining energy and momentum with the research project over this seven and a half year period. It has been very important to be able to explore philosophy, challenge established practices and question ideas with these supports. Regular meetings with my supervisory team and rigorous discussion have honed my observations and arguments and enhanced the research and writing processes.

I felt a sense of isolation as a postgraduate student – I didn't know anyone else undertaking a PhD at my university for the first two years of my research. With the support of my supervisor I initiated a networking group for MCH nurses, graduate students and academics interested in maternal and child health research. A small group of 4-8 people meet every 6-8 weeks over lunch or dinner to network and discuss issues in research. Being able to discuss issues, share concerns and offer and receive support has been a rich nurturing and sustaining experience. Through this forum I established contact with another MCH nurse undertaking a PhD at another university and this connection was great for mutual support and encouragement. Over the period of writing the final chapters of the thesis I also found it beneficial to explore research and writing issues with a 'thesis writing circle' I co-initiated. Lively debate about issues in research, information sharing and peer support have been important in maintaining progress.

Discussions about the writing process have also enhanced the process of writing up the research insights.

Support from my professional colleagues has also been crucial in the research journey. The team of maternal and child health nurses I worked with were also a source of ongoing support and encouragement from the early days of writing the proposal, organising field work and analysing data. Continuing interest in my progress, and what remained to be done was likewise very encouraging.

The Challenge of Writing and Re-writing

Although I usually enjoy writing, writing this thesis has been challenging and painstaking at times. I have learnt by my own lived experience to value my supervisors' advice to choose a thesis topic that I am passionate about and that will sustain my interest over the long haul of nearly eight years of part time study. There were tensions between getting sections of writing completed and keeping the project moving forward. The risk of becoming bogged down in the writing or focusing too intently on perfecting small sections of the work and not progressing appropriately came to fruition all too often. Over the course of my journey as a research student I have followed the model of completing rough drafts of my thesis chapters and moving ever forward towards a completed first draft of the thesis. In the first period of my candidature I progressed rapidly, beginning data collection early and simultaneously writing the theoretical framework and method chapters. As I pushed onward with conducting the research the writing was completed mostly in a draft form that required much more work. This approach was useful for progressing through the chapters but it was problematic as by the time the first draft was collated there were major sections that required extensive re-structuring and re-writing.

This issue of writing and re-writing does, however, resonate in a positive sense with van Manen's hermeneutic phenomenology where the process of writing and re-writing is both an art and a key research activity. It has been beneficial to the outcome of the project to reflect on and refine the language used to explore the phenomenon of early motherhood and the research process undertaken to explicate this.

How Phenomenology has Influenced My Practice

I am conscious that my maternal and child health practice was influenced and changed by my experience of van Manen's phenomenology. This may have been due to the experience of exploring women's stories of lived experiences in the research interviews, or from integrating phenomenological principles as I have worked to understand the underpinning philosophy.

As a clinician with a long gap between masters and doctoral studies I have found it difficult to grasp some of the philosophical aspects of phenomenology and as such it was a steep learning curve. Nonetheless, I was excited by the deeper awareness I have of the lived experience of individual women and their families. This became apparent to me in the following ways:

Firstly, my active listening has been enhanced and I am hearing the individual experience in women's birth and mothering stories and recognising that each individual is unique. Phenomenology has helped me to think more holistically and consider how a particular experience or situation impacts on a particular person. I am also recognising afresh that what constitutes reality is different for each individual. I am also aware of greater recognition of time, place and context issues for families. This may involve the readiness of the family to recognise or acknowledge issues or to consider the broader picture. Finally I am more mindful of using a collaborative approach in my work with new mothers and new families.

Phenomenology is a very person-centred, holistic and respectful philosophical framework to underpin midwifery and maternal and child health nursing practice. It provides rich thick descriptions about lived experiences that can inform practice and promote increased understanding. Understanding the lived experience of the client and their situation, in all its complexities, is at the core of family centred practice. I have come to see phenomenology as an extremely useful research approach with which to both explore issues such as women's lived experience of early motherhood and as a respectful philosophy to underpin family centred practice.

Conclusion

I am reminded of the song *Birth is a Journey* (Latham 2005). In the same way that pregnancy, birth and motherhood are a journey, my research project has also been a journey. As a midwife, maternal and child health nurse and mother I have journeyed to new understandings in my exploration of early motherhood. There have been challenges and sometimes obstacles, but in spite of these the research journey has progressed due to factors such as the generous sharing of participants, ethics application procedures, agency support, the guidance of my supervisors and support from colleagues. Learning about phenomenology has been a big challenge. At times it has been difficult and at times even uncomfortable to simply 'trust the method', but as my journey as a researcher with this study draws to a close it has been, on reflection, a deep joy and most satisfying to use this theoretical approach.

Birth is a Journey

A Song by Fiona Latham (2005)

Never knew it could touch me so deep inside
Never knew the sound of a baby's cry
Never knew it could bring silent tears to my eyes
And I never knew the strength that I could find,
And never knew what waited on the other side

Birth is a journey leading you on
Have faith in your body, you've got to be strong
Don't lose your faith now, you've got to believe
Let it lead you on and on and on
Never knew what a mother could feel inside
Never knew where this journey would lead my life
Never knew how much change it could bring to my life
And I never knew the joy that I could find
And I never knew how deep the love would feel inside

Birth is a journey leading you on
Faith in your body, You've got to be strong
Don't lose your faith now, You've got to believe
Let it lead you on and on and on

Oh, in one short day the pain quickly fades
As you're left staring at this brand new face
So much left to love as the days sweep on by
As your journey leads you on. Leads you on

Oh, I never knew the strength that I could find
Never knew what would be on the other side

Birth is a journey leading you on
Faith in your body, You've got to be strong
Don't lose your faith now, You've got to believe
Let it lead you on and on and on
Let it lead you on and on and on
Let it lead you on and on and on. And on.

Chapter 10

Conclusion

'We know more about the air we breathe and the seas we travel, than about the nature and meaning of motherhood'

Adrienne Rich (1976:11)

This comment was made over 30 years ago. Sadly it is probably still correct today. We live in a world where we can send men and women into space, refuel aeroplanes mid-air, grow babies in test tubes and yet not really understand much about the experience of early motherhood.

Introduction

This concluding chapter draws together the insights gleaned from the earlier chapters of this thesis. It will begin by discussing the strengths and weaknesses of the study, and then briefly review the study method and insights. The main focus of the chapter is to articulate insights explicated from each of the themes followed by identification of the implications arising from this study in relation to practice, education and research for the professions of midwifery and MCH nursing. The chapter concludes by presenting a framework for incorporating these implications into midwifery and MCH nursing practice, education and research in the sphere of early motherhood.

Strengths and Limitations of the Study

It is pertinent at this stage to reflect on the strengths and limitations of the study to give balance to the arguments made and the insights gleaned from undertaking this thesis. The purpose of such an approach is to contextualise what the study offers to the development of new knowledge. Although the study was carefully designed with

significant consideration given to ethical issues, some limitations can be identified and need to be taken into consideration when reflecting on these insights.

Limitations of the Research

Firstly, the insights from a small cohort such as in this phenomenological study cannot be generalised to the population. Nevertheless the meanings identified of women's experiences of early motherhood and the understandings generated provide deeper insight into some women's experiences, not understood or available from other methodologies.

As a doctoral study the research was financially constrained by a small budget, which meant limited funding for costs such as travelling in a rural area . This meant collection of women's stories and experiences was restricted to the rural municipal area where the researcher resides. In addition, the location of the study in a rural area may be considered a limitation as the particular municipality is quite mono-cultural and does not have the vibrant multicultural perspective that may have been available in a metropolitan area. While in one sense women birth the same the world over, in another sense women's experiences of early motherhood may have been influenced by distance from townships, the metropolitan area and access to services and support networks. However, living in a rural area was only mentioned as an issue by one participant. As the focus of the study was women's experiences of early motherhood, the differences between birthing in rural and metropolitan areas were not part of this dissertation.

The changing face of what is normal was initially seen as a limitation or problem that impinged on this study. Normal pregnancy and normal birth are becoming elusive in the current situation of maternity care and this study has highlighted the difference between what is usual or common and what is normal. It was problematic to find a normal pregnancy and uncomplicated birth in the particular cohort of healthy pregnant women invited to participate in this study. There was a high level of intervention in the birthing process – from induction of labour, employment of technologies that limit women's movements leading to a cascade of intervention from epidural analgesia to obstetric vacuum, forceps and caesarean birth. These situations of contemporary maternity

practice lead to a redefinition of what is normal or usual. In this study after losing participants from the study due to complications of preeclampsia and hypertension in pregnancy (although not resulting in adverse outcomes) application was made to the ethics committee to reconfigure what was considered 'normal' in this study. The criteria were extended to include women with preeclampsia or hypertension in pregnancy provided there was no adverse outcome for mother or baby.

In addition, interview errors did occur in this study. While attempts were made to engage participants in comprehensive in-depth conversations about their experiences of early motherhood, occasionally the researcher omitted to ask a participant to explore or describe some situations further, or failed to ask participants to clarify some aspect of what they were relating. Occasionally participants were also interrupted by the researcher to clarify some detail and this may possibly have broken their train of thought. These errors were noted on some early transcripts but were reduced as the interviews progressed and the researcher gained experience; nevertheless they need to be acknowledged.

On reflection, it may also have been useful to have asked all participants the same baseline questions as part of each interview. Using an unstructured interview format provided information relating to some participants, but it was not realised until the interviews were transcribed that it may have been useful to have each person's perspective on certain issues or experiences, for example, feeding their baby for the first time. This technique would however clash with the chosen phenomenological approach.

Strengths of the Research

This research project is characterised by a number of key strengths. Firstly, it gives voice to women's experiences concerning an area that has been largely unspoken about in the academic world. Women's experiences of early motherhood have been revealed in rich, thick and detailed descriptions. The insights of the study are pertinent to midwifery, maternal and child health nursing and family medicine and inform practice in all areas. These insights are also useful for expectant and new mothers generally and their family members. In terms of the study itself there are a number of strengths in the

research design that add to, and underpin, this benefit to the knowledge about the lived experience of motherhood. These include: the transparency of the study, having hermeneutic phenomenology as the theoretical framework for this study, and the emphasis on respectful treatment of participants and other stakeholders.

The transparency of the research is an indisputable strength. All elements of the process were audited and overseen by the researcher's supervisors. A rigorous approach was adopted from the formulation of the research question through to development of the proposal, seeking ethics approval, data collection, exploring data and the formulation of the research results. All stages of the research were conducted ethically and the resulting insights have a high level of integrity because of the rigorous research process.

An additional layer of transparency in this research project was the active involvement of participants in the interviews. Experiences discussed were explored and clarified to ensure the accuracy of the descriptions of lived experience and often checked at a later stage of the interview or in a subsequent interview. This enabled participants to refine and explicate what they were sharing. Further to this, six transcripts were returned to participants to review. Feedback concerning the interviews affirmed what was said. One participant requested a slight modification to her comments as she felt she had been too dramatic at the time and this was attended to.

Having a series of interviews built into the research design enabled the interviews to be conducted at three key stages of early motherhood. This process extended data collection from being a mere 'snap shot' to revealing lived experiences across the transition to early motherhood. Furthermore, this strategy added increased depth to the understanding of women's experiences.

A further strength of the research is the adherence to van Manen's hermeneutic phenomenology as the theoretical framework for this study. While it is popular to combine methodologies in a mixed methods approach, in having pursued a purely phenomenological approach there is a certain value added to the research topic explored in this thesis. The topic investigated has been broad, but the use of phenomenology has facilitated the revealing of rich and detailed descriptions that elucidate women's lived experiences of early motherhood, and has kept the focus directly on this phenomenon.

In keeping with phenomenological inquiry, a key strength of this study has been the respectful manner in which participants and stakeholders have been regarded and kept informed. This is important in all research, but has underpinned this project to an exceptionally high level. This has included the participant supports built into the study design, such as provision of participants with a list of local resources for new mothers, availability to contact the researcher between interviews and flexibility with interview times and locations. Participants and stakeholders were also given feedback about the study's progress and preliminary insights through project newsletters.

Reflection on the Study

Summary of the Research Method

This study involved 13 participants from an area of rural Victoria, Australia. All were first time mothers aged 18 years of age or older having an essentially healthy pregnancy when invited to participate in the study. Each of the participating women were interviewed at three key stages about their experience of early motherhood. These times were respectively in the last six weeks of pregnancy, and approximately two weeks and eight weeks after giving birth. Four participants also kept journals of their experience between late pregnancy and eight weeks after birth. The interviews were all audio-taped and transcribed verbatim. van Manen's hermeneutic phenomenological approach was used as the theoretical framework guiding the study and accordingly thematic analysis of the data involved a holistic reading of the text, a selective highlighting of the text, and a detailed line by line analysis (van Manen 1997:92-93).

Study Insights

The study insights have been presented in chapters 5, 6 and 7, and have been discussed at length in chapter 8. They are briefly reviewed here chronologically.

Pregnancy

The pregnancy interviews revealed a number of themes concerning women's experiences of early motherhood at that stage. For these first time mothers, their pregnancy resulted in a raft of changes to their lives. They were transformed from being a woman to becoming a mother. The participants' view of the world altered and they began to 'see life differently' and perceive that they were creating a family.

The lived experience of the physical and emotional fluctuations of pregnancy involved significant changes for most participants, and rich descriptions of these were shared, extending existing knowledge. The physical experience of pregnancy entailed varying intensities of morning sickness that ranged from mild nausea to vomiting exacerbated by smells and movement to severe retching. A swelling rounded the abdomen declared the pregnancy publically and made the pregnancy more real for participants and their partners. Participants' stories of interacting with their not-yet-born babies revealed new knowledge concerning maternal-foetal play and interaction.

The waiting experience of pregnancy was enmeshed and entangled with anticipation, excitement and anxiety and was depicted vividly. It included waiting to share the news of the pregnancy, preparing for the new baby, and the perception that the pregnancy was going to go on forever. As their pregnancy progressed women held numerous questions in their minds. They reflected on life and death and wondered about the interconnectedness of life. More musings and wonderings washed over women as the birthing time approached: When would labour start? Would their partner be with them? How would the labour progress? Would their baby be alright? Would they themselves be alright? Would they be able to breastfeed? and so on. Increasing reflections crystallised the trepidation some women experienced. Women pondered and tried to imagine what being a mother would be like and what they would be like as a mother.

Relationships during pregnancy manifested some changes. Support from partners included additional household help, over protectiveness and shard communication, but this occurred to varying degrees. Some participants perceived that having a baby completed their relationship with their partner and made them more united. For participants who were single, disclosing their pregnancy to their partner was awkward; involving anxiety, uncertainty and procrastination. Pregnancy had a significant impact on the lives of these women whether they maintained a relationship with the father of their child or not.

Labour and Birth

Insights regarding women's experiences of labour and birth indicate that confusion and uncertainty pervaded the experience of recognising the onset of early labour and their 'waters breaking'. Women's individual experiences were different from those recalled from books or educational classes. These women experienced strong labour as arduous and challenging. It was a very physical experience which affected their whole body, causing shaking legs, cramping feet, breathing disordered by stress and for those with long labours a sense of loss of control and despondency. Women used a range of physical and psychological strategies to manage the pain with most progressing on to the spectrum of medical pain relief options. Time was generally experienced differently during labour, dragging initially and then moving quickly as contractions increased in strength and frequency.

Attentive concern, caring conversation and giving physical comfort created a safe and reassuring environment for these women to labour and give birth. For many the sustaining presence and encouraging support of a partner was at the core of getting through labour. Some women were also supported by family members. Women in labour valued the care of midwives in helping them through labour, feeling protected and safe with the midwife in control. They also appreciated being given information about their progress. Several women described moments of intense communication with their doctor during labour and birth, such as deep eye contact, feeling listened to or being affirmed.

Concentrated effort was required in the second stage of labour to endure the pain of very powerful contractions while pushing the baby down the birth canal. For most participants the first meeting between the mother and infant was characterised by wonder, elation and incredulity that the baby was born. Others felt exhausted, dazed or flat after a prolonged labour or complicated birth and did not have any energy remaining to hold or engage with their baby. Women generally perceived their newborn infants as warm, soft and beautiful when introduced, even if they were still covered in blood.

Medical interventions were experienced by most participants. Women experienced the use of technologies such as intravenous lines, cardiotocograph (CTG) machines and epidurals as confining and irksome, restricting movement and comfort measures such as walking around during labour or the use of showers or baths. Participants having a caesarean birth experienced numerous concerns as they were prepared for surgery. They did not experience any pain during their operation but were aware of sensations of being pushed, pulled and prodded and at times their entire body jerking around.

Postnatal

The insights regarding the postnatal period revealed that while some participants felt physically well immediately after birth many initially experienced weakness, fatigue and limited movement due to prolonged labour, epidural anaesthesia, perineal pain, caesarean wounds or spinal headache. Perineal sutures were described as painful and women reported feeling swollen and bruised. The pain and discomfort was multiplied several fold for those with third degree tears and women had difficulty walking from their beds to a chair. Having a caesarean wound was generally described as not as painful as expected, but women struggled to juggle attachments such as intravenous infusions and urinary catheters and found it difficult to rely on others to help with showering or breastfeeding.

Women experienced a number of physiological changes in the early postpartum period. Women's breasts underwent dramatic changes in fullness as milk 'came in' and their abdomens were floppier and had lots of loose skin. However, women felt lighter and

less restricted than when they were pregnant and found it easier to sleep comfortably. Most participants described feeling hesitant and anxious about using their bowels for the first time after having their baby and some expressed concern about their perineum tearing or splitting open. Intense stinging when voiding was experienced by some women due to perineal or vaginal tears after a vaginal birth. Physical tiredness affected almost all participants and was expressed in feelings of not coping, as well as feeling stressed.

Learning to breastfeed was harder than participants anticipated and all described different degrees of nipple pain. Women struggled with trying to manage intravenous lines, urinary catheters, painful perineums, surgical wounds, large blood clots and conflicting advice as they concurrently entertained visitors, manoeuvred crying babies, and learnt to breast feed. While some women received extensive help and support from midwives, a few described less optimal assistance. Mothers, sisters, and partners were also a significant source of support for new mothers as they learnt to breastfeed.

Learning to mother was a profound and intense experience. Elation, wonder and pleasure were juxtaposed with feeling anxious, overwhelmed, and worried about postnatal depression. Lack of knowledge about how to soothe a crying baby or helping a baby to settle to sleep was compromised further by uncertainty and confusion. Women were distressed themselves to hear their baby crying. There was a clash between the expectations of motherhood and the reality of caring for a newborn baby. Becoming a mother involved a shift from women just thinking about themselves and their partner to being responsible for a vulnerable new baby. As their understanding and experience increased women became more confident and their emotions settled.

Women experienced significant challenges in their relationships during the early motherhood period. While having a baby brought many couples closer together, tiredness, lack of intimacy, and sleeping separately heightened frustration in some relationships. Women's early relationship with their infants varied; some women felt immediately flooded and overcome with love for their new baby while others experienced a more gradual bonding with their infant. Interpreting and understanding infant communications was initially difficult but over a period of weeks most women began to recognise some of their baby's communications. Women were delighted when

their infants began to respond and interact with smiles and cooing. Women's relationships with their own mother were also important during the transition to motherhood. Most women had a supportive relationship with their own mother and received emotional support and practical help. Those women whose mothers were absent due to distance or death greatly missed their presence as the support and comfort of one's own mother was seen as unique and central to becoming a mother. A few participants experienced their mother as intrusive due to visiting too often or too late. Although becoming a family was celebrated in the period immediately after childbirth, families were preoccupied postnatally with physical recovery from the birth, learning to care for their baby and interacting with extended family and friends.

Implications for Midwifery and MCH Nursing Practice

The key insights gleaned from the explicated themes of women's experiences of early motherhood concerned 'seeing things differently', 'waiting', 'wondering', the 'intense physical and emotional experience', 'relationship changes' and the experience of 'learning to mother'. These are components of the lived world of early motherhood and part of van Manen's four fundamental phenomenological existentials of lived time, lived space, lived body and lived relation to the other (1997:102). Like the four existentials these insights form what van Manen terms an 'intricate unity' that can be differentiated from one another but not separated (1997:105). Consideration of the implications of these insights for midwifery and MCH nursing follows.

Seeing Things Differently

Having a baby brought a raft of changes to women's lives and transformed them into mothers. As their view of the world changed women began to see things in a different light. This developmental phase is important for midwives and MCH nurses to be cognisant of as it is an opportunity for providing support to women as they reflect on the philosophical impact of their pregnancy on their life, baby and family.

Waiting and Wondering

Over the course of their pregnancy women had many experiences of 'waiting' and 'wondering'. These included the excitement of anticipating the baby and involved making arrangements and preparing the 'nest'. As each participant's pregnancy progressed toward term the women grew increasingly tired of waiting and sensed that they would be 'forever pregnant'. Women's minds considered many questions, and 'wondered' and pondered thoughts during their pregnancy. They also mused and pondered on labour and birth, their baby and partner, and themselves as mothers. Midwives and MCH nurses can help prepare and equip women for these experiences of waiting and wondering by providing women with evidence based information and education about labour and childbirth, breastfeeding and early parenting so they have the appropriate information to optimally manage. These 'waiting' and 'wondering' periods of pregnancy are also an opportunity for midwives and MCH nurses to establish rapport and provide essential support to women.

Intense Physical and Emotional Experience

During pregnancy and the perinatal period women experience major bodily changes and fluctuating emotions. Lack of knowledge, about changes associated with pregnancy and the perinatal period, and uncertainty regarding the onset of contractions and rupture of membranes were also common. During labour and birth women experienced stress, fear, felt overwhelmed and lacked confidence and trust in their bodily processes. Labour required endurance. Some situations were associated with a cascade of medical interventions and consequences, such as foetal monitoring with cardiotocography leading to inactivity and consequences such as prolonged labour, epidural analgesia, instrumental delivery, a sleepy baby, or newborn feeding problems. Women experiencing complications such as postpartum haemorrhage or second or third degree vaginal tears also experienced tiredness, fatigue, and physical pain and discomfort. The physiological changes of the postnatal period can cause women to experience pain or discomfort, tiredness and fluctuating emotions. Emotional and social changes of the postnatal period can cause women to feel tearful or overwhelmed, 'not knowing' or joyful or ecstatic. Lack of knowledge about the positive or negative changes associated

with pregnancy or the perinatal period can exacerbate the situation and associated distress.

These issues have implications for, and pose challenges to, midwifery and MCH nursing. Midwives and MCH nurses need to have a working knowledge of women's physical and emotional experiences of pregnancy and the perinatal period. This understanding needs to be embedded in practice in terms of providing evidence based information about the normal physiological changes of pregnancy, onset and progress of labour and the puerperium. Similarly, evidence based care to promote a healthy pregnancy, normal labour, physical recovery after childbirth and to support the emotional transition to motherhood needs to be entrenched in core practice. The physical and emotional experiences of the perinatal period are intensified several fold during women's experiences of labour and childbirth. Midwives caring for women during labour are challenged to facilitate normal labour and birth. This has implications for supporting and empowering women, observing and monitoring progress, providing evidence based care, acting on variations of the normal and referral to specialist services as appropriate. These issues also have implications for midwives and maternal and child health nurses in terms of political activity, such as challenging public perspectives on the experience of birthing and advocating for optimal birthing services for women.

Relationship Changes

Relationships were challenged by pregnancy, birth and the ultimate arrival of a new baby into a family, and often underwent much change. During pregnancy women experienced changes in their couple relationships. For some this involved increased closeness, understanding and shared communication; this occurred to varying degrees. Women who were single at the beginning of their pregnancy described their relationship with the father of their baby as more complicated and less supportive. Women also began relationships with their unborn baby at this time. During labour and birth women were vulnerable, dependent and fearful. In the puerperium women's relationships with their partner involved living the tensions of the changing nature of their relationship. Postpartum, partners were the main source of emotional support for most participants, however levels of tension varied between couples and irritability strained some

relationships to the point of conflict. Sharing the parenting was problematic in some relationships, as was maintaining intimacy. In broader relationships having support from their own mother was highly valued by some women while other women found it intrusive. There was also tension or distress concerning absent or missing mothers. Women's relationships with their baby often began during pregnancy and postnatally 'getting to know my baby' was important to them. Falling in love with the baby was immediate for some women but gradual for many, and their learning to interpret baby communications helped in fostering the mother-baby relationship.

Women experience significant changes and challenges in their relationships across the pregnancy and perinatal period. Midwives and MCH nurses are in a position to provide information and education about relationship changes and communication strategies during this time. During pregnancy in particular it is important for midwives and MCH nurses to promote and assess maternal-foetal attachment. During labour and birth midwives can promote and facilitate communication between birthing women and their support people and provide sensitive support and encouragement. During the postnatal period midwives and MCH nurses need a working knowledge that relationships undergo significant stress and change when couples become parents and that it sometimes takes time to develop a warm relationship with a new baby. Midwives and MCH nurses are in a central role to reassure women that learning how to mother and interpret infant cues develops over time and to support women with this.

Learning to Mother

The study insights about women's experiences of learning to mother comprised two key areas; these were 'learning to breastfeed' and 'learning to mother'. Learning to breastfeed was both a physical and emotional experience. It was physically intense and intimate and occurred when women were experiencing 'so many things happening' and were trying to make sense of conflicting advice. Women often lacked confidence and knowledge, describing 'not knowing' what to do, and feeling 'I'm not going to be able to do this' or that they did not have enough milk. They described feeling guilty for being a bad mother and that breastfeeding was 'the hardest thing.' Over time women gained skills and confidence as they 'got it all together' or decided to stop

breastfeeding. The experience of 'learning to mother' was also both a physical and emotional experience. It involved 'not knowing' the practicalities of caring for a baby such as feeding, settling and recognising baby cues, and learning by trial and error. It involved living with crying and integrating the baby into one's life and was described as 'a lot harder than expected.' These issues have implications for midwives and MCH nurses in terms of the need to engage mothers with evidence based information about learning to mother such as feeding, settling and recognising baby cues. It is also important to support women learning to mother and to maximise consistent evidence based information to avoid, or at least minimise, conflicting advice.

The issues underpinning women's experiences of early motherhood have been delineated here and the corresponding implications for midwifery and MCH nursing have been highlighted.

Application to Practice, Education and Research

Having identified the implications the next step is incorporating these into midwifery and MCH nursing clinical practice. It is suggested that this can be done by means of a model that integrates practice, education and research (Figure 10.1). This model includes a number of key implications that need to be considered in midwifery and maternal and child health nursing. and which provide a direction for midwifery and MCH nursing education, and further research.

Overarching Implication

The insights from the study indicate that the overarching concept for midwives and MCH nurses is to develop a framework for care that fosters a supportive, nurturing 'holding' environment for women across pregnancy, the perinatal and early motherhood periods. This 'holding' environment is one that enables a woman to experience the phenomenon of early motherhood safely and confidently with optimal emotional support for relationships. The concept of 'holding' was originally developed by Donald Winnicott (1965) for use in psychotherapy. This involved the therapist recreating a 'holding environment' resembling that of the mother and child. In midwifery and MCH nursing practitioners have a crucial role in supporting and 'holding' women, so that they can support and 'hold' the infant and family.

Key Implications for Clinical Practice The following key implications are important to include in midwifery and maternal and child health nursing practice:

1. Engagement of women in discussing any concerns.
2. Empowerment of women to feel safe and confident.
3. Support for communication between women, their partner and extended family.
4. Affirmation and promotion early parenting skills.
5. Promotion, protection and support for breastfeeding.
6. Advocacy of woman-centred midwifery care and family focused MCH care.

Some of these key implications are already a part of practice in some areas. However these may operate in discrete or disconnected ways or not be fully actualised across a particular practice setting. The proposed model clearly articulates the connection between practice, education and research and aims to maximise a supportive, nurturing 'holding' environment for pregnant women and new mothers. Actions that can be taken to operationalise the key implications are outlined below.

1. **Engagement of women in discussing any concerns** about their perinatal or early motherhood experience to
    a. Address women's spoken and unspoken concerns
    b. Foster collaborative and therapeutic partnerships, and
    c. Complete psychosocial assessment

2. **Support for communication between women, their partner and extended family,** including
    a. Assisting couples to plan and negotiate new roles and responsibilities,
    b. Discuss assertive communication and mutual support.
    c. Challenge women and families to consider the baby's experience.
    d. Explore how baby could be integrated into the family.

3. **Empowerment of women to feel safe and confident** through
    a. A relationship with a known midwife and regular MCH nurse, and

b. Understanding the normal physical and emotional changes of pregnancy, labour and early motherhood.

4. **Affirmation and promotion of early parenting skills**.
    a. Offer early parenting education antenatally and postnatally so couples can explore key early parenting information.
    b. Facilitate problem solving.
    c. Teach parents to recognise infant cues and attachment behaviour and explore the innate capabilities of the newborn.
    d. Normalise bonding of the foetus/infant as a gradual process.
    e. Explore sleeping and settling processes.

5. **Promotion, protection and support for breastfeeding** by:
    a. Implementing the World Health Organisation guidelines (1998)
    b. Embedding the evidence based ten steps to successful breastfeeding in hospital practices and seven step national community program in community services.
    c. Prioritising the midwifery and MCH nursing role in spending time with women during early feeds to support optimal feeding experiences and to offer positive feedback.

6. **Advocacy for woman-centred midwifery care and family focused MCH care.**
    a. Promote pregnancy and labour as normal physiological experiences unless indicated otherwise, build confidence and provide support for woman to trust their body.
    b. Acknowledge the importance of supporting and 'holding' the mother so she can support and 'hold' the infant and family.

Key Implications for Education

1. Further Training in Counseling Skills

Resource midwives and MCH nurses with training to further enhance counseling skills, focusing on:

- Eliciting and addressing women's spoken and unspoken concerns,
- Family strengths, conflict resolution, family counseling techniques
- Identifying, supporting and referring women affected by issues such as mental illness, family violence, trauma or other psychosocial factors.

2. Further Training in Woman-Centred Practice

Resource midwives and MCH nurses with training to further promote woman-centred and family practice.

- Extend knowledge of psychosocial determinants of health.
- Extend knowledge of physiological and emotional aspects of pregnancy, birth and perinatal period.
- Enhance skills to teach women about what is normal during pregnancy, birth and early motherhood.
- Extend knowledge of the nature and extent of women's health issues generally and particularly after childbirth.
- Highlight early motherhood as an opportunity to address key health issues.

3. Further Breastfeeding Education

Resource midwives and MCH nurses with further training to support, promote and protect breastfeeding:

- Provide basic education about the WHO guidelines for successful breastfeeding, including clinical skills to support new mothers.
- Enhance skills to teach women about what is normal during breastfeeding
- Establish a structured, tiered framework for ongoing education to maintain and enhance skills in supporting women to breastfeed.

4. **Training in Early Parenting Skills**

Resource midwives and MCH nurses with further training to educate parents and to support and promote early parenting skills:

- Provide further education about adult learning principles for use individually or in groups.
- Extend knowledge about transition to parenthood issues
    - Support communication between women, their partner and extended family, including changing roles and responsibilities, integrating baby into the family and exploring support options.
- Undertake education package about infant mental health and attachment theory, including innate capabilities of the newborn, recognising infant cues and attachment behaviour, supporting infant settling.

Key Implications for Research

Where the above framework for clinical practice and education are implemented it is recommended that research evaluate the outcomes on current midwifery and nursing practices, culture and education. Ongoing research is necessary to assess the effectiveness of the change process and inform midwifery and MCH practice outcomes. Key elements for study are:

1. **Evaluate women's experiences of early motherhood**

- To assess the effectiveness of improved communication and education.
- To investigate the integration of woman –centred / family centred practice.
- Broad exploratory study of women's experiences.

2. **Evaluate women's experiences of midwifery and MCH nursing care**

- To assess the effectiveness of improved communication and education.
- To investigate the integration of woman –centred / family centred practice.
- To explore women's experiences and perceptions of continuity between midwifery and MCH nursing care.
- To evaluate the most acceptable and appropriate model for delivery of education to childbearing families.

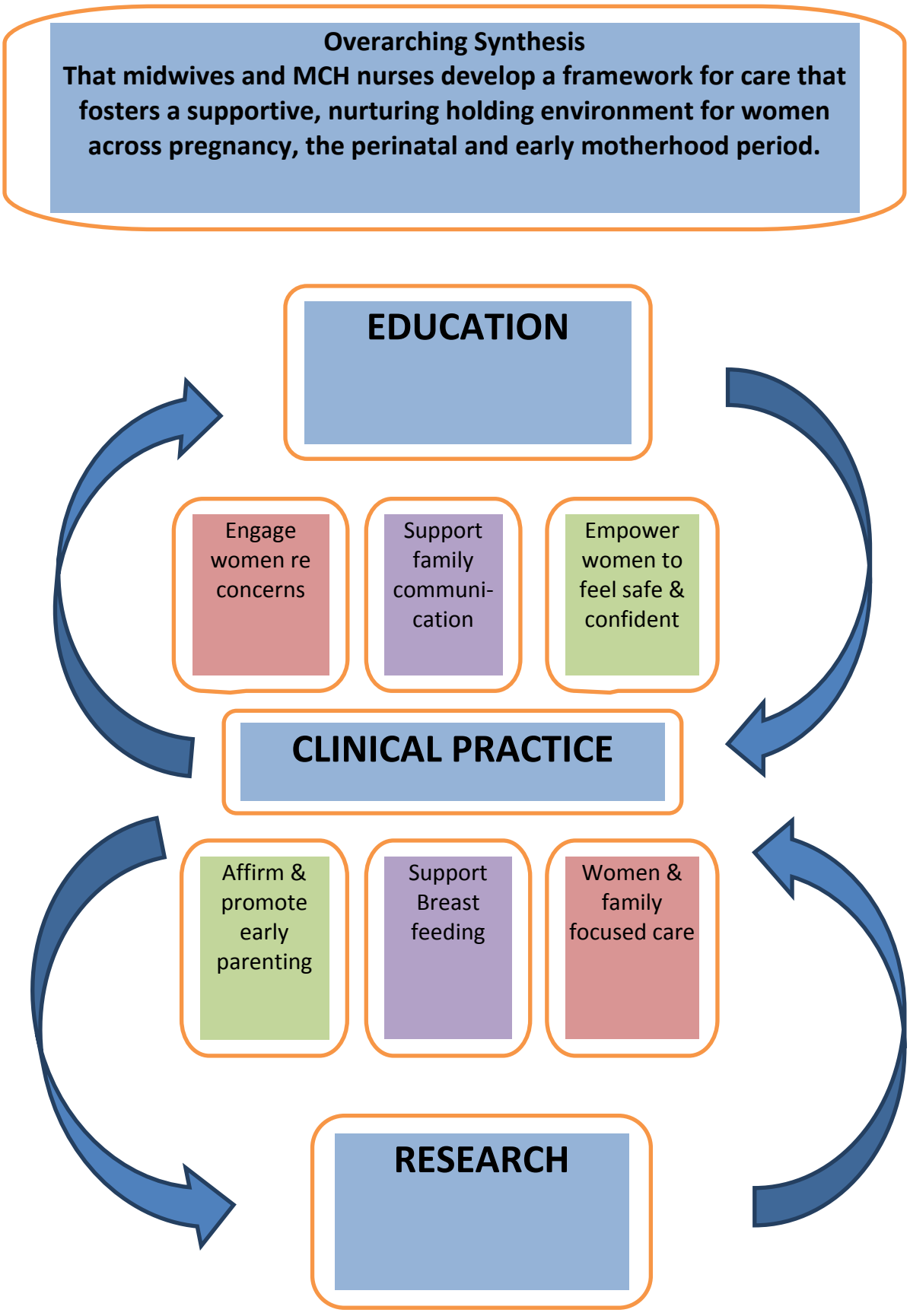

Figure 10.1: Early Motherhood Practice Model

3. **Evaluate the promotion, support and protection of breastfeeding**

- Monitoring of breastfeeding rates,
- Explore and review breastfeeding practices and support, coupled with
- Exploratory study of women's experiences of breastfeeding.

4. **Explore new parent's experiences of early parenting**

- Investigate new parents' understanding of infant mental health principles and the experience of incorporating them into daily life.
- Exploratory study of new parent's experiences of early parenting and what they identify as the joys and challenges.

5. **Explore pregnant women and new mothers' experiences of 'being held'**

- Exploratory study of women's experiences of pregnancy and perinatal period.
- Consider what women experience as supportive and appropriate.
- Evaluation of enhanced communication and woman-centred training.

Conclusion

Becoming a mother for the first time is a significant transition in women's lives. This thesis has explored and explicated the experiences of early motherhood for the cohort of Australian women who participated in this study. While this research study has been concluded and offered for critique and comment by the academic community, from a phenomenological perspective the investigation of the phenomenon of early motherhood cannot be completed. This is because the ongoing lived experience of time, body, place and relationships will continue to offer fresh and renewed understandings that contribute to and reveal the essence of the phenomenon of early motherhood for women in other places and times. Nonetheless, the insights presented here contribute a rich understanding and awareness of this phenomenon. The challenge remains for midwifery and MCH nursing to reflect on the insights provided by the study and to use these to value, protect, nurture and support women's experiences of early motherhood.

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Appendix 1

Advertising Poster

Research Project

"Mum's the Word":

Exploring Early Motherhood

- **Are you a healthy expectant mum?**
- **Is this your first baby?**
- **Is your baby due March – June 2005?**
- **Could you help with this research?**

Participation in the study will involve being interviewed at three key stages about your experience of early motherhood. The information will be used to help women understand the experience of early motherhood and provide health professionals with new information about women's experiences of being a mother.

Please ring me if you are interested or would like more information,

Leanne Sheeran Tel: 0405 537 808
Midwife, Maternal & Child Health Nurse, & PhD student RMIT University

***Please note that women living in Kilmore & Wandong /Heathcote Junction will unfortunately not be able to participate in the study.*

Appendix 2

Advertising Pamphlet

Postal Address:

"Mum's the Word"
Research Project

C/- Broadford Post Office
Broadford, VIC 3658

Further Information

Confidentiality

All information collected as part of the study will be kept in strict confidence and any identifying features will be removed to ensure anonymity.

Interviews

Can be conducted at a place you find comfortable, such as your home or elsewhere if you prefer. It is anticipated interviews will take about one (1) hour. They will be recorded on audiotape and then later transcribed to allow analysis of themes.

What supports are available for you?

Each participant will be linked to a primary MCH Nurse (not the researcher), employed to provide the Maternal and Child Health service.

A list of local community support services such as counselling, social work, local MCH services, PND support services and 24 hour MCH Telephone Advice Line will be provided to all participants.

The researcher will be available from late in your pregnancy until 8 weeks after the birth [including between interviews], to discuss your feelings or experience of being a mother.

Do you have further questions?

Please call me if you have any further questions about the study. I would be happy to talk with you.

Leanne Sheeran Tel: 0405 537 808

Research Project

Mum's the Word:

Exploring Early Motherhood

Women having a normal pregnancy with their first baby are invited to participate in this study of early motherhood.

The aim of the study is to explore women's experiences of early motherhood.

Leanne Sheeran, a local Maternal and Child Health Nurse and Ph.D. student at RMIT University is conducting the study. The Dept of Nursing and Midwifery, RMIT University will supervise the study.

Why is the study important?

While there is a lot written about motherhood, there is little detailed research about the experience of early motherhood as described by women.

The information collected in the "Mum's the Word" project will be used to help women and families understand and better anticipate the experience of early motherhood. It will also be used to provide health professionals with new information about women's experiences of early motherhood.

What does taking part involve?

Taking part in the study involves sharing your experience of early motherhood with me, Leanne Sheeran, by:

1. Taking part in one hour interviews at three (3) key periods:

   - 34 -38 weeks gestation of pregnancy;
   - 2-3 weeks after your baby is born;
   - 6-8 weeks after your baby is born.

2. Sharing any music, photographs, or literature that are important in your experience of early motherhood.

3. It would also be helpful, but not essential, if you could write down any thoughts about your experience of early motherhood during the study period in a personal journal (diary).

The main question to be discussed during the interviews is: What is being a mother like for you at this time?
You do not have to discuss anything that you feel uncomfortable about, or any issue you do not want to talk about. Your partner is welcome to attend the interview if desired.

Who can take part?

You are invited to participate in this study if you are:

- English speaking, a first time mother, and 18 years of age or more,
- Between 28-34 weeks of pregnancy, and
- Have not had any problems with your pregnancy.

[Kilmore and Wandong/Heathcote Junction residents are unfortunately not able to participate in the study.]

Would you like to take part?

If you are interested in taking part in the study, or would like further information, please mail this form to me at the address listed on the next page. If you prefer you can telephone me, Leanne Sheeran, on

Tel: 0405 537 808

I would be happy to discuss any questions about the study or talk about what taking part would involve.

Research Project

Mum's the Word:

Exploring Early Motherhood

I am interested in the research and would like further information. Please contact me to discuss the project further.

Name: ... ...

Address: ... ...

... ...

Postcode: ... ...

Telephone:

Home: ... ...

Mobile: ... ...

Date Baby is Expected: ... ...

Appendix 3

Press Release

Mum's the Word

WOMEN who are pregnant for the first time and come from the Broadford, Wallan, Beveridge, Seymour and Puckapunyal areas are being invited to participate in an important research project.

The Australian Nursing Federation has awarded district maternal and child health nurse Leanne Sheeran a $2500 research grant to explore women's experiences of early motherhood with first-time mothers living in the Mitchell Shire.

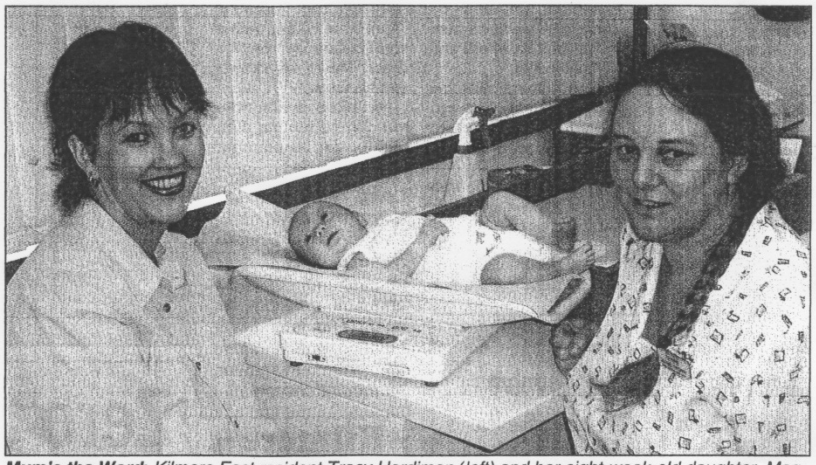
The information collected in the project will be used to help women and their families understand and better anticipate the experience of early motherhood.

It will also be used to provide health professionals with new information about women's experiences of early motherhood.

Leanne lives in Broadford and has been a maternal and child health nurse with Mitchell Shire for ten years.

She is presently employed at the Kilmore, Wandong and Pyalong child health centres.

"While there is a lot written about motherhood, there is little detailed research about the experience of early motherhood as described by women," Leanne said yesterday.



***Mum's the Word**: Kilmore East resident Tracy Hardiman (left) and her eight-week-old daughter, Maggie, with district maternal and health nurse Leanne Sheeran.*

She intends carrying out the research project for a PhD at RMIT University while taking long service leave.

"I am hoping about 15 mothers will come forward for the 'Mum's the Word: Exploring Early Motherhood' project.

"Confidentiality will be maintained. All information collected will be kept in strict confidence, with any identifying features removed to ensure anonymity," Leanne explained.

The Department of Nursing and Midwifery at RMIT University will supervise the study.

The main question about to be discussed with first-time mothers is: What is being a mother like for you at this time?

A midwife and mother of three boys herself, Leanne is keen to get the project underway as soon as possible.

Women who are aged 18 years and over and have reached 28 to 34 weeks into a normal pregnancy are being sought for the project.

There are three interviews involved, one in the 34 to 38 weeks stage of the pregnancy, and the others about two weeks and eight weeks after the baby is born.

"Mums will not have to discuss anything they may feel uncomfortable about, or any issue they do not want to talk about. Partners are welcome to attend if desired," Leanne said.

The annual ANF grant was established to promote and encourage members to undertake innovative and creative nursing practice that can be transferred across practice environments.

Women from the Broadford, Wallan, Beveridge, Seymour and Puckapunyal areas who are interested in taking part in the study, or require further information, can contact Leanne on 0405 537 808.

Appendix 4

Engagement of Participants

Details re Engagement of Participants and Non – Participants

Table: 1 Engagement of Participants

DETAIL	Number of Participants	Participant Code No.
Total number of participants initiating contact with researcher.	**4**	1,2,3,5
Participants initiating contact by telephone	1	1
Participants initiating contact by mail	3	2,3,5
Total number of participants engaged following direct approach by researcher	**9**	4,6,7,8,9,10, 11,12,13
Participants recruited by personal approach at antenatal clinic		
**Kilmore Birth Unit (attended ……clinics)	4	7,9,10,13
**Seymour Maternity Service (attended 3 clinics)	2	4,12
Participants recruited via presentation at antenatal education class		
**Kilmore (attended 3 or 4 classes)	3	6,8,11
**Seymour (attended 1x class)	0	0
TOTAL PARTICIPANTS	**13**	

Table 2:

Details re First Time Mothers who initially indicated interest but did not commence study

Participant	Location Engaged	Reason	Outcome
A	KBU -antenatal clinic	• Hypertension at 38 weeks. • Treated with rest at home, then with medication, then admission to hospital for rest.	• Telephoned researcher and advised about admission to hospital. • Labour induced, term baby. • No further complications.
B	Seymour –antenatal clinic	• Not known	• Did not reply to messages to arrange initial interview. • Lost to contact
C	Seymour –antenatal clinic	• Changed mind and moving house.	• Sent text message to researcher and advised about decision. • Cancelled appointment for first interview.
D	KBU -antenatal clinic	• Changed mind after reading participant information sheet in detail.	• Telephoned researcher and advised about decision. • Cancelled appointment for first interview.
E	KBU -antenatal clinic	• Hypertension diagnosed 3rd trimester. • Required hospitalisation and medication commenced prior to 1st interview.	• Induced, term baby. • No further complications
Total First Time Mothers Expressing Interest but who did Not Commence Participation			**Five (5)**

Table 3: First Time Mothers approached at Antenatal Clinics who declined to participate

LOCATION	No.	REASONS OFFERED IF ANY
Kilmore Birth Unit	5	Close to term, feeling anxious, moving away, will think about it, not interested
Seymour Maternity Services	2	Not interested,
Total	**7**	

Appendix 5

Ethics Approval letter

RMIT UNIVERSITY
SCIENCE, ENGINEERING AND TECHNOLOGY PORTFOLIO

Office of Research and Innovation

Building 201
Plenty Road
Bundoora VIC 3083
Australia

PO Box 71
Bundoora VIC 3083
Australia

Tel. +61 3 9925 7096
Fax +61 3 9925 7098

Building 10
124 La Trobe Street
Melbourne VIC 3001
Australia

GPO Box 2476V
Melbourne VIC 3001
Australia

Tel. +61 3 9925 3949
Fax +61 3 9925 3747
www.rmit.edu.au

26th October 2004

Leanne Sheeran
151 High Street
Broadford
Vic 3658

Dear Leanne

FLSAPP 28 – 04 'Mum's the Word' Exploring early motherhood

Thank you for submitting your amended application for review.

I am pleased to inform you that the committee has approved your application for a period of **38 Months** to **December 2007** and your research may now proceed.

The committee would like to remind you that annual reports are due during December for all research projects that have been approved by the Human Research Ethics Sub Committee.

The necessary form can be found at:
http://www.rmit.edu.au/browse;ID=6sqqx7sd0wkp;STATUS=A?QRY=human%20ethics&STYPE=ENTIRE

Yours faithfully,

Barbara Polus,
Chair, Science Engineering & Technology
Portfolio HREC Sub-committee (Life Sciences)

cc: **Gay Edgecombe**
Diana Donohue
Anthony Welch

Appendix 6

Pro forma Statement of Support from Agencies

CONFIRMATION OF SUPPORT

From Medical Clinic for

Proposed PhD Research

To: R.M.I.T. University Human Research Ethics Committee

This letter confirms that:

1. I have read the details about the proposed research (attached)

2. This Medical Centre is supportive of Leanne Sheeran accessing our facility to invite interested first time expectant mothers to participate in the doctoral research program titled: "Mums the Word: Exploring early motherhood" subject to the R.M. I.T. University Ethics Committee Approval for the research project.

3. We understand involvement of our medical centre in this study would include:
   (a) Display of posters and pamphlets about the research program, and
   (b) Distribution of pamphlets to expectant mothers at 28-34 weeks gestation inviting them to take part.

SIGNED ……

NAME (Print) ……

POSITION ……

DATE: ……

TELEPHONE ……

CLINIC NAME ……

ADDRESS ……

……

Appendix 7

Participant Information Sheet

RMIT University

Participant Information Sheet

School of Health Sciences
Nursing and Midwifery

Bundoora campus west
Building 201
Plenty Road
Bundoora VIC 3083
Australia

PO Box 71
Bundoora VIC 3083
Australia

Tel. +61 3 9925 7453
Fax +61 3 9467 1629

Hamilton campus
Glenelg Highway
Hamilton VIC 3300
Australia

Tel. +61 3 5572 0500
Fax +61 3 5572 0555

Sale campus
PO Box 886
Bairnsdale VIC 3875
Australia

Tel. +61 3 5142 2460
Fax +61 3 5142 2477
www.rmit.edu.au

Title of Research: Mum's the Word: Exploring Early Motherhood

Dear Participants,
My name is Leanne Sheeran. I am undertaking a Doctor of Philosophy degree in maternal and child health nursing at RMIT University. This information letter provides details about this research study so you can decide if you would like to participate.

What is the study about?

The aim of the study is to explore women's experiences of early motherhood. The information collected in the "Mum's the Word" project will be used to help women understand and better anticipate the experience of early motherhood. It will also be used to provide health professionals with new information about women's experiences of early motherhood. Dr Gay Edgecombe and Dr Tony Welch from the Division of Nursing and Midwifery, RMIT University are supervising the study.

Who is invited to take part?

You are invited to participate in this study if you are:

- English speaking, a first time mother, and 18 years of age or more,
- Between 28-34 weeks of pregnancy, and
- Have not had any problems with your pregnancy.

What does taking part involve?

If you are willing to participate in this study it will involve sharing your experience of early motherhood with myself, Leanne Sheeran, by:

1. Taking part in one hour interviews at three (3) key periods:
   - 34 -38 weeks gestation of pregnancy;
   - 2-3 weeks after your baby is born;
   - 6-8 weeks after your baby is born.
2. Sharing any music, photographs, or literature that are important in your experience of early motherhood.
3. It would also be helpful, but not essential, if you could write down any thoughts about your experience of early motherhood during the study period in a personal journal (diary).

The main question to be discussed during the interviews is: What is being a mother like for you at this time? You do not have to discuss anything that you feel uncomfortable about, or any issue you do not want to talk about. Your partner is welcome to attend the interview if desired.

Participation

Your participation is voluntary and I will need your informed consent. The interviews can be held at your private home, or somewhere else that suits you. Interviews will be limited to one (1) hour duration unless you indicate you wish to continue for a short period beyond this. If difficulties arise you may change an interview to another day. Each interview will be audiotaped and transcribed for the purpose of analysis. You can review the transcribed interviews if you wish, and the final report will be made available to you at your request. You can withdraw from the study at any time, and this will not in any way affect the support you will receive from the Maternal and Child Health service. If you decide to withdraw from the study any information provided by you will not be used without your permission.

How will you remain anonymous?

All information shared by you will remain confidential. In the study your identity will be protected by the use of a pseudonym and removal of identifying information. I will be the only one aware of your identity. Access to data will be strictly limited to participants accessing their own information (if desired), and secretarial support (for transcription of audiotapes). My supervisors Dr Edgecombe and Dr Welch will have access to the coded transcripts to monitor the progress of the study. It is important for you to be aware that your information can only

Appendix 8

Consent Form

Attachment 4: Consent Form HREC Form 2b

RMIT UNIVERSITY
HEALTH SCIENCES

RMIT HUMAN RESEARCH ETHICS COMMITTEE

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

Nursing and Midwifery
Building 201
Plenty Road
Bundoora VIC
3083 Australia

PO Box 71
Bundoora VIC
3083 Australia

Tel. +61 3 9925 7453
Fax +61 3 9467 1629
www.rmit.edu.au/nursing

FACULTY OF: Portfolio: Science, Engineering and Technology

DEPARTMENT OF: Division of Nursing and Midwifery

Name of participant:

Project Title: "Mum's the Word": Exploring early motherhood

Name(s) of investigators: (1) Leanne Sheeran Phone: 0405 537 808

(2) Phone:

1. I have received a statement explaining the interviews involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews have been explained to me.
3. I authorise the investigator to interview me.
4. I acknowledge that:
   (a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   (d) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to RMIT University, and the respective Council and hospitals involved in the recruitment process. Any information, which will identify me, will not be used.

Participant's Consent

Name: _____ **Date:** _____
(Participant)

Name: _____ **Date:** _____
(Witness to signature)

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745. Details of the complaints procedure are available from the above address.

Quality Endorsed University

Appendix 9

Research Checklist and Confidential Fieldwork Notes

Research Checklist : **Pseudonym:** **Participant number**:

Date of initial contact: … … … … … … … □ Read Flyer or Provided with Flyer
□ Phone conversation about project
□ Discuss any questions about project

Check re Criteria for Participation
□ English speaking
□ 1st baby
□ Age
□ Gestation of pregnancy (recruit 28-34wks): … … … …wks EDD: … … … … … … … … … …
□ Booked hospital for birth : Kilmore □ Seymour □ Other: … … … … … … …
□ Town of residence (not Kilmore, Wandong or Pyalong) …….
□ Normal pregnancy –
- □ No known problems during the pregnancy
- □ Single baby, not multiple pregnancy
- □ Pregnancy 37-42 weeks duration
- Any formal medical treatment for any of the following: Yes □ No □
  - Gestational diabetes
  - Hypertension,
  - Pre eclampsia or other complication
  - Premature labour

□ Set interview time & place

□ Give participant information sheet

□ Discuss participant information sheet

□ Participant's Journal -discussed

□ Discuss availability of researcher to discuss early motherhood experience

□ Obtain written, informed consent

□ Copy of consent form provided to participant

□ Provided with "Resources for Mum" information sheet.

□ Check that typist unknown to participant.

Interview Process Proceed? Yes □ No □

Interview 1. Date: Location: Duration: Introduce journal:

Interview 2. Date: Location: Duration: Discuss Journal

Interview 3: Date: Location: Duration: Discuss & collect journal

Copy journal Yes □ No □ Date:… … … … … … …
Return journal to participant Yes □ No □ Date: … … … … … … …

Confidential Fieldwork Notes: Participant Number:

** * * only place where personal details are recorded * * **

Name: Phone:

Pseudonym: Best day /time to phone:

Partner's Name:

Partner's Pseudonym:

Booked Hospital for birth : Kilmore □ Seymour □ Other: … … … … … … …

Expected Due Date: Actual Birth Date:

Background Details:

Participant's DOB: Partner's DOB:

Address:

Marital status: Single / Defacto Couple / Married / Separated

Occupation (Participant): Occupation (Partner):

Children living in the house: eg step children

Medical History:

- □ Asthma
- □ Heart condition
- □ Depression
- □ Operations
- □ Regular medications
- □ Diabetes
- □ Kidney problems
- □ Other health issues

Gynecological History:

Women's health issues

Any concerns this pregnancy? (Only exclude if requiring medical intervention)

Previous pregnancies:

- Spontaneous miscarriages
- Terminations
- Adverse Outcome after 20 wks gestation

Type of maternity care?

Private or Public maternity care

Midwife

GP

Obstetrician

Appendix 10

Transcripts

Draft 1: 6th Sept 2005; ANALYSIS OF TRANSCRIBED INTERVIEW OF ANGELA

R =	Researcher (Leanne Sheeran)
A =	"Angela", participant
B =	"Brett", Angela's husband
Date of interview:	10th May, 2005
Location:	Angela's home, on a large rural block a few kilometres from the nearest small rural township. We sat at the dining room table in her large open plan house. Angela was 40+3 weeks gestation.

R1: Thank you for agreeing to talk with me today about your experiences of being a mum. Can you tell me what being a mum is like for you at the moment?

A1: Um... there's a bit of apprehension I think. I think a lot of excitement. You sort of get to the labour stage and I said to a girlfriend today, I said I can't sort of envisage going past that at this stage coz I haven't actually been there (laughs). But I said to her, you know, this time next week I might actually be holding a baby – that's our baby. And I said to her that its really hard to get my mind around the fact that I'll have this baby for the rest of our lives, you know, it's going to really change our lives but it's going to be a positive thing, I think. We've had a pretty hard year so...

A describes feeling some apprehension. She is waiting for labour to begin. She recounts how she shared with a girlfriend that she can't envisage anything past that stage.
She knows that next week she might be holding her baby. It is hard to get her mind around the fact that their baby will be present (theirs) for the remainder of their lives. It will be a big change for their lives, but it will be a positive thing. A's family has had a hard year.

Feelings of apprehension and excitement while waiting for labour to start.

Hard to imagine:
-Anything beyond the labour stage.
- That next week the baby will be here.
-The baby will be present for the remainder of their lives.

The arrival of the baby will be a positive thing for the family, which has had a hard year.

Because I lost my mum to cancer when I was actually nine weeks pregnant. And she'd only just found out. Yeah, and I was glad that she found out. But um... I mean it's been a positive thing I think being pregnant because it's given everyone something else, we sort of haven't had time just to dwell on only mum's death. Whereas because we knew that this was something that she really wanted as well, like she really wanted to be a grandmother. And um... I had been trying to fall pregnant for it would have been easy twelve months and we were just getting ready to have tests and we actually went to Fiji on a holiday to watch my brother who

A's mum died from cancer when A was 9 weeks pregnant. A's mum had known about the pregnancy, and A was glad that she knew. A's pregnancy was a positive thing for A's family, as A's mum was pleased about it and wanted to be a grandmother.
A had been trying to fall pregnant for a 12 months and she and her husband were getting ready for tests when they went on a holiday overseas.

Importance of pregnancy:
-Link between birth and death:
-Death of A's mum when A 9 wks pregnant
-Pregnancy seen as positive as A's mum wanted to be a grandmother.
-12 month period of trying to fall pregnant

plays in the men's Australian Netball Team. And of course over there we got drunk and we forgot about it (laughs). And we came home and um... I think the day I found out I was pregnant was the day we found out mum had about four weeks to live. Which was really hard to deal with. And that's why I think I bled a lot a nine weeks, just the whole stress of the funeral and you know, just dealing with it in... well the way you do deal with it. But yeah so at least she knew before she passed on.	They relaxed and forgot about trying to conceive and came home pregnant. The pregnancy was confirmed the same day they found out A's mum had about 4 weeks to live. This was really hard for A to deal with. Dealing with it was difficult, and A attributes the stress of the funeral as contributing to the bleeding she experienced at 9 weeks of pregnancy. However A describes dealing with it as something you just do.	Pregnancy happened when A & B relaxed and forgot about trying to conceive. Pregnancy shadowed by Grief: -Pregnancy confirmed same time that A's mum's given terminal diagnosis of 4 weeks to live. -Stress of funeral linked to bleeding that occurred at 9 weeks of pregnancy. -Dealing with it is something you just do.
R.2: It must have been a difficult time because you've got this pregnancy and this baby that you're waiting for...		
A.2: And we didn't tell anyone like, Brett and I we chose to tell obviously mum and dad and I've got four brothers and we told Brett's mother and father, we didn't tell his sisters. Um... just because I didn't want it to be... it was hard enough everyone saying "oh you poor thing you've lost your mum" and then it would have been "oh you poor thing you've lost your mum and oh, hang on your pregnant as well". So... um... but it was a really positive thing. Probably about four weeks afterwards I was about thirteen weeks when we told everyone. I mean it made my Nan cry for three days (laughs). You know, and like I said to her it would have been something mum would have really wanted and I know that she's with us, you know.	A and B told their parents and A's brothers about the pregnancy but waited until A was 3 months pregnant before sharing the news with anyone else. A found it hard with everyone sympathising about her mum's illness and death without the adding the pregnancy. When they announced the pregnancy at 3 months it was a really positive thing. A's Nan cried for three days, and A said to her it was something her mum would have wanted, and A knows her mum is with her.	Sharing the news of pregnancy -Just parents and A's family initially -Waiting to 3 months Sympathy for mother's illness and death difficult - Need to keep the pregnancy separate for a time. - Announcement at 3 months was positive. -Shared sorrow and shared joy. -Holding on to wishes and desires of the deceased mum.
R.3: She died at nine weeks?		
A.3: Yes, when I was pregnant at nine weeks. Yeah she passed away, which was hard. Terrible morning sickness (laughs). So I was going... and we were at the Seymour Hospital and that's one of the reasons that I decided to go through Seymour because it's such a great support network up there. Like, the nurses and that are just	A's mum died when she was 9 weeks pregnant, and this was hard. A had terrible morning sickness. She spent long periods at the local hospital during her mum's final weeks.	Pregnancy shadowed by A's mum's terminal illness. Support at local hospital valued – influenced choice for maternity care.

brilliant and um... it was only probably yeah, after I told everyone and my dad's next door neighbour actually works at the hospital and she came over and she said "now we know why you're spending a lot of time in the toilet" (laughs). Because I was so sick. And you know, when someone is sick people bring up food all time coz you don't leave the hospital much and yeah, they were forcing all this food down my throat and I was sitting there and I was pale as and everyone kept saying "The stress is terrible, you're just not coping well are you?" (laughs). And I was like "No, actually I'm coping all right it's just I feel nauseas twenty-four hours a day". But yeah...	People kept bringing food to the hospital. A was pale and people assumed she was very stressed and not coping very well. She felt she was coping okay, just nauseous 24 hours a day.	Culture of caring for families experiencing serious illness by bringing food. Difficulty in accepting food during 24 hour per day morning sickness (which was hidden).
R.4: They thought you were upset and grieving...		
A.4: Yeah, and it was probably that as well. But um... the pregnancy definitely was affecting me (laughs). Yeah, I was sick. It was yuck. Yeah, so....	The pregnancy made A feel quite sick (with nausea).	Morning sickness
R.5: What was it like when your pregnancy was first confirmed?		
A.5: Um... I was... we were thrilled, yeah. We were, we were so excited. Brett just wanted to tell everyone straight away. Um... yeah, coz I was only five weeks I think so only just gone and um... it was hard just keeping it to ourselves. But it was nice, it was a nice little secret to have.	When A's pregnancy was confirmed A and B were very excited and thrilled. Brett wanted to announce the pregnancy straight away, but they decided to keep it a secret for a little while.	Decision to keep pregnancy a secret for a period.
R.6: What did it feel like?		
A.6: Um... I don't know that I felt any different for a while. Um... just sick. Yeah I had really sore breasts, I remember that. They were really sore, I mean even to have a sheet on them at night time I was like "oh!". Um.. and yeah, just the nausea. But yeah, I was thrilled. It was a real achievement after we'd been trying for so long you sort of, it becomes all you focus on, you know, "oh I've got to get pregnant,	With the pregnancy A says she didn't feel any different for a while, just sick. Her breasts were really sore, even to have a sheet on them at night was painful. She was thrilled though. It was an achievement after trying do long. A says that when you are trying for so long it becomes	Body: -Nausea /morning sickness -Really sore breasts – too sore to have a sheet touch them. Pregnancy as an achievement after trying for so long.

I've got to get pregnant" and when you finally do and you think "Wow, in nine months or ten months time I'm going to have a baby". It was unreal. I'm glad it did happen um... at the time it did happen. Although in saying that when we had to bury mum and that I was thinking it was the worst thing in the world because, you know, I thought "God, how am I going to cope with a baby and I'm not going to have my mum there". Because, you know, you need your mum there, as a bit of support network and we were really close, really close. But um... I've got fantastic friends and my mum's sisters are all around so... you know, I've got a great support network and I'm really close to my dad and that as well. So... yeah so I'm finding it's going to be a good thing.

all you focus on. "I've got to get pregnant." A was glad she became pregnant when she did. When they had to bury her mum she thought it was the worst thing in the world: she wondered how she was going to cope with a baby without her mum there. A thought she needed her mum there as a support, and A and her mum were really close.
A says she has fantastic friends and her mum's sisters are all around so she has a great support network. A says she is really close to her dad as well, so she feels she will be supported.

Trying for a pregnancy over a long period become intense focus.

Relationships:

Difficult feelings:
-How can you cope with a baby without your mum?
-Your mum is very important for support.

Identifying other support networks:
-Aunties
-Friends
-Own father

R.7: (Missed on tape) How has it been for you, with being pregnant and losing your mum?

A.7: Well I have had a few times where I've fallen off the cart I suppose, especially in the last few months. Um... because we had Christmas to get over and then mum's birthday you know, and it's the first of everything. Like my first birthday without her, first mothers day and there was a while... um... oh, there were a few issues with the whole how the will went and what not, and my dad was actually away a lot so... and mum comes from a large family so I felt that I was carrying the burden of that a lot. And I think it was probably almost two weeks solid I cried every day and I just thought, I can't... I just didn't feel I could get out of the um... the rut that I was in. But eventually I did.

When asked about how it has been, being pregnant without her mum, A said there had been a few hurdles especially the last few months;
Anniversaries like Christmas and her mum's birthday, and events like her first birthday without her mum and her first mother's day.
There were some issues with the will, and A's dad has been away a lot and A felt she was carrying the burden of it a lot.
There was a period of almost two weeks when A cried every day and thought and felt she could not get out of the rut she was in.

Pregnancy shadowed by death of mum:

-Anniversaries are hurdles: Christmas, Birthdays, Mother's day.

-Carrying the burden of family responsibilities while Dad away.

Two week black period:
-Crying everyday
-Feeling stuck in a rut

R.8: So you're sort of saying it had highs and lows?

A.8: Yeah, absolutely highs and lows. Yeah. And sometimes I don't actually think it takes anything in particular to trigger it off, I don't know whether it's just a bad

A confirmed she experienced highs and lows. She said it didn't take anything in particular to trigger it, but

Emotional roller coaster:

-Highs and lows

hormone day or you know, Brett will sort of walk in and you know, I'll just burst into tears. Yeah, I don't know whether it is directly affected by that or whether that is just being pregnant anyway. Because some of my friends have said to me they were really emotional when they were pregnant and really sensitive to things so maybe that just accentuates the whole thing a bit more, I don't know.	Brett might walk in and she would just burst in to tears. She wasn't sure if it was the grief or being pregnant. Some of A's friends had shared that they were really emotional and sensitive to things when pregnant, so A wondered if the pregnancy accentuated her emotions a bit more.	-Bursting into tears -Distinguishing between pregnancy and grief Friends report being very emotional during pregnancy, so perhaps pregnancy accentuated grief.
R.9: Because I think any of those reasons, the combination…		
A.9: Yeah, that's right so… but you just sort of learn to… well, I've just found I just try not to think about it too much, you know. If I wake up and it's a bad day, then it's a bad day and I just get through the day because tomorrow is another day and yeah, the sun might shine tomorrow and it might be a good day.	A found that she managed it by trying not to think about it too much. If she has a "bad" day she just accepts it is a bad day and focuses on getting through it. Tomorrow will be another day and might be a good day.	Management of grief and emotions by trying to not think about things: -Managing a bad by just getting through it -Tomorrow could be a better day.
R.10: When it's a bad day and you get through the day, how do you get through the day?		
A.10: Um… I have a best friend who I can and do ring at any time. Sometimes you find it hard talking to your partner. Um… he still has his parents. So, um… not that he doesn't understand because he was really close to mum as well. But… um… I think sometimes maybe he's too close.	A gets through a bad day by phoning her best friend. She says it is sometimes hard talking to your partner. A's explains that it is not that B doesn't understand, because he was also close to her mum. She thinks it is possibly that he is too close.	Relationships: Best friend can be called at anytime. Sometimes you need support from someone who is not your partner = not so close.
R.11: It's not his mum.		
A.11: Yeah, it's not his mum. He can still pick up the phone and ring her for anything whereas my best friend her parents divorced and she doesn't see her father, and not that I say that that is the same sort of thing, but I just find her to be understanding, easy to talk to. I can ring her and just be crying and she knows what to say to me, you know. (Voice breaking slightly). So I'd say it's friends.	A says she finds her best friend is understanding and easy to talk to. If she phones and she is crying her friend knows what to say to her. Her friend helps her get through when it is a bad day.	Relationships: A good friend knows what to say, even if you are just crying. It is friends that help you get through a bad day.

ANALYSIS OF TRANSCRIBED INTERVIEW OF XERRI

R =	Researcher (Leanne Sheeran)
X =	"Xerri", participant
T =	"Thomas", Xerri's husband
Date of interview:	29th March, 2005
Stage of motherhood:	Postnatal. It is 2 weeks +3 days since Xerri gave birth.
Baby:	"Rose" is in her cradle, settling down to sleep.
Duration:	60 minutes
Location:	"Xerri's" home, at the dining room table. Periodically "Rose" cries and Xerri attends to her by rocking the cradle or patting her. At a later stage when Rose doesn't settle we pause the interview while Xerri changes her nappy. After that Xerri nurses and rocks Rose in her arms as we talk and Rose cries intermittently. Towards the end of the interview Xerri breastfeeds her daughter.

1.R: You have just had your baby and she is now two weeks old, can you tell me a bit about what being a mother is like for you at the moment?

1.X: Um... it's a bit unsettling at the moment because I'm generally... I like having a routine and patterns and that sort of thing. Um... the first week was very difficult at home, I found that my emotions I was up and down all over the place. I didn't think I was going to cope, I was thinking "I'm going to be one of these people who gets this post-natal depression and...". One minute I'd be crying then I'd be happy, screaming and... I was a mess. And it didn't help with Thomas being sick either I think that made a big thing. 'Coz he was very upset that he couldn't even hold her so it was very, very hard. I didn't think I was going to get through it, put it that way. But umm... the second week has been a lot easier at home. She's sort of settled a little bit better and I'm coping a lot better just hearing her cry, here we go (baby crying)... she'll be alright. Umm... like I couldn't even handle hearing her cry at the start but now it's sort of... I know, you know, I

X's life has changed since Baby Rose was born. She describes herself as a person who likes having a routine and patterns.

X says that the first week at home was very difficult. X's emotions have been "up and down and all over the place". She didn't think that she was going to cope. She wondered if she might get PND. She would be crying one minute, then happy and then screaming. She wondered if she would get through it.

X's husband was ill with shingles and wasn't able to be close to their newborn baby because of concern re infection. Xerri says this was very very hard.

The second week home was a bit easier for X. Xerri says that her baby has settled a little bit better and she herself can cope a lot

LIVED TIME

Life has changed

Unpredictable routine

LIVED BODY
Emotional roller coaster

(See literature re early motherhood)

Extra stress with sick husband.

know she has to cry she's a baby, it's her way of communicating.	better hearing Rose cry. *(Xerri's baby begins to cry).* At the start X. says couldn't even handle hearing Rose cry. Now X says she understands that crying is how Rose communicates.	2nd week – coping with baby crying better.
2.R: How did you feel when she was crying? You said it was hard to listen to.		
2.X: Umm… I think she could feel that I was unsettled by it. 'Coz she tends to know if I'm upset and she was very hard to settle down then. Umm.. but yeah, it made me feel… it made me feel sad. It sort of broke my heart to see her crying and… yeah I felt like I couldn't do anything right. That I couldn't get anything right to settle her down. So, yeah it was hard. But she's doing good now… see? She's gone back to sleep. (Laughs)	X says that her baby could feel that she was unsettled by her crying. X says the baby's crying made her feel sad and like her own heart was broken. X felt like she couldn't do anything right, that she couldn't get anything right to settle her down, and that it was very hard. As we spoke the baby settled herself and X seemed pleased that the baby was able to settle to sleep.	LIVED BODY EMOTIONS Unable to settle baby's crying – feeling helpless Feeling distress for baby's distress –unable to placate
3.R: You said your moods were up and down a lot the first week.		
3.X: Yeah. I think it didn't help that I was in a lot of pain with my stitches and everything. It was just overwhelming. We had a house full of people and yeah, it was very hard. And the fact that I'm used to getting sort of eight hours sleep straight without any interruption and going to you know, two and a half – three hours sleep and then up for an hour feeding her and then… it was hard to get used to. But I'm feeling a lot better now, I'm coping better. And I'm getting, even though it's a broken sleep, I'm getting a good seven and a half to nine hours a night so… thank God! So yeah, no, it's not too bad.	X describes some of the difficulties after childbirth. • she had a lot of pain with the stitches in her perineum, • there was a house full of people, and • she was only getting a 2-3 hours sleep and then up for an hour to feed the baby. This was hard to get used to, but now X is getting 7-9 hours sleep a night, although it is still broken by feeds. Xerri says that she feels a lot better, and that she is coping a lot better.	FIRST WEEK Postnatal issues • Pain • Overwhelmed by too many people around the house • Exhaustion • Feeling not coping SECOND WEEK -Feeling better -Coping better -More sleep, although broken
4.R: Sleep is pretty important.		
4.X: Yeah oh definitely. I can't function without sleep. I find that I wake up brain dead.	X says that she can't function without sleep	Sleep essential to functioning.
5.R: Most people do I think.		

5.X: Yeah, so it's much better. Thomas has been good this week he sends me off to bed at 2.00pm in the afternoon and.... "quick the baby's asleep you're going to bed". So, it's good having him around. He's got another week off too.

X's husband has been feeling better himself this week.

He encourages her to sleep when the baby does.

Husband encouraging X to rest when baby does.

6.R: You said the first week you were home you had a lot of people here. Were they visiting or staying or?

6.X: No, they were helping. It was relatives and things like that. It was good but I felt that all I wanted to do was sleep or sit back and relax a little bit. And even though nobody was expecting cuppas to be made or anything like that, everyone was pitching in doing dishes, putting washing out, doing the floors all that sort of stuff. I still felt like "can you all just leave me alone, just go?" you know. "I feel like I want to ball my eyes out and I don't want to do it in front of you, so go away."
But my mum actually umm... I called her one night and we were having a bad night. The first night I came home my milk came in, and I didn't know that when your milk came in they got colicky. So I should have stayed in hospital another night. But I rang mum at 4.30 in the morning and "I can't settle this baby down I don't know what's wrong with her." And Thomas had just been diagnosed with the Shingles, so he couldn't really do a lot other than sort of hold her out here and you know... But umm... mum came round and she said "Right, go and jump in the bath. Have a good cry, and go have a Milo and get in to bed". So that was a help, that was really good. And I needed that I did. I went in and turned the fan on so no one could hear me and just howled, just balled my eyes out for half an hour and it felt better. So yeah, that was good.

The people in X's house were relatives and others helping.
X says that this was good, but all she wanted to do was sleep or sit back and relax.

The visitors were all pitching in doing things to help, but X really wanted them to go and leave her alone.

X wanted to 'ball (her) eyes out" but didn't want to do it in front of all these people.

X called her mum at 4.30am when she was having a bad night the first night she was home. She couldn't settle the baby and she didn't know what was wrong. As her husband had shingles he couldn't come close tho the baby.

X's mum came around to their house. X's mum told X to have a bath and a good cry, and then to have a Milo and go back to bed. X said she had bath and turned the fan on so no one could hear her and then howled for half an hour.
X said that helped and was really good, she needed it. Xerri says that she balled her eyes out for half an hour and it felt better.

LIVED SPACE

X had lots of helpers.

But X wanted space to be alone & cry.

LIVED OTHER

X 's mum came to help at 4 am on morning when X was distraught.

Mother Supportive
-Xerri's mum sent her to have a bath and a cry and then a sleep.
-This was a big help for Xerri.

7.R: How did it feel like while you were crying?

7.X: Oh I kind of overwhelmed. But I couldn't… I don't know, I felt like I couldn't cope with it all I thought this is all too much I just don't know what I'm doing. And why have we done this? And umm… yeah it was hard.	X said when she was crying she felt overwhelmed. She felt she couldn't cope; that it was all too much, she didn't know what she was doing and questioned why they had done this (had a baby).	Crying and overwhelmed. It's all too much What have I done?
8.R: What did you expect yourself to be able to do?		
8.X: Oh I don't know. I'm sort of, I think I have expectations… well, my expectations of myself are a little bit too high and I always want to do better than what I….you know, better than what I think I can at everything I do. So, to not to be able to settle the baby, and not be able to have the house 100% spotless, and not be able to get that washing out that's been sitting in the basket for 7 hours that was all getting to me. And it actually helped having one of my girlfriends who was actually at the birth, she's really really good to talk to and very calming. She came in and just said "So what, your washing's been sitting there for 7 hours, leave it go for two days". I'm like "You can't do that" and she said "My oath you can, just leave it!" And I've deliberately even, like the sink is full of dishes now. I've left it. I'm leaving it because that's what she said to do. Just leave things. If there's dust over there – leave it. You've got to learn to live with it because it's going to be there tomorrow and it's going to be there again next week. There's nothing you can do about it. So, I think just having her to talk to at 4.00 in the morning when, you know, when I need someone to chat to and Thomas is asleep, that has helped a big deal.	X says her expectations of herself were a little bit too high. She says she always wants to do better than what she thinks she can at everything she does. X found that not being able to settle the baby, and not being able to have the house 100% spotless, and to have the washing sitting in the basket for 7 hours was all getting to her. Her girlfriend, one of her support people, was supportive. She spoke with X at 4 am in the morning and X found her very calming and good to talk to. She told X it didn't matter if her washing was in the basket for two days, that it was fine to just leave. X feels better about leaving dishes and dusting, and is trying to deliberately leave things in the house that are not important, and that will still be there tomorrow. X's friend was supportive to talk to when her husband was asleep and she needed someone to chat to.	LIVED TIME High expectations challenged by reality of baby. LIVED OTHER Support person • Calming • Permission to not be perfect • Permission to leave household tasks for a while • Practical advice
9.R: And how are you finding that sort of… how do you feel now that you're leaving everything?		
9.X: I'm more relaxed. I actually do feel better about just leaving it. So, because I know that you can't do everything I'm not super mum. It's just… you're going to get there eventually. (Baby crying)… go to sleep. But yeah, we're getting there	X says she feels more relaxed about leaving housework and recognises she isn't super mum. X's says her husband has been good preparing meals and doing dishes etc.	LIVED SPACE /TIME More relaxed about house work

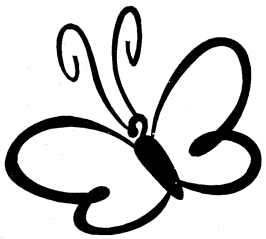
and like I said Thomas has been good he's been doing the little meals and doing the dishes and that sort of thing so that's helped.	Baby Rose is crying on and off in the background. X is balancing talking to researcher and assessing if her baby needs attending.	
10.R: If you want to get her just say anytime.		
10.X: Yeah, she might be… she's right. She just has a grizzle.		
11.R: Can you tell me a bit about what's happened since I saw you last, because I saw you when you had four weeks to go? So what's happened with you since then?		
11.X: Oh, the last couple of weeks were hard because everyone at the hospital was saying "Oh the bubs is going to be here soon, are you having pains" and they were expecting it to be right on the forty weeks and I went to 41 ½ weeks… so,	The last weeks of the pregnancy were hard on X. The hospital had been saying the baby would come soon as she was having pains. X's pregnancy continued past her date and over 41 weeks	LIVED BODY Prolonged pregnancy – 8 days over due date.
12.R: That's a long time isn't it?		
12.X: It is and I was just getting so anxious and I was over it. I was kind of… I couldn't sleep properly and I just couldn't do anything. I was having trouble just going for a walk without you know, without feeling completely buggered by the end of, you know, by the end of the street. And umm… it was hard. And they told me I think my last visit to the hospital that they were inducing me on the Tuesday and that helped. I thought beautiful at least I know by Tuesday we're going to have this baby, that's it. But I went in to labour the Friday morning by myself so, yeah that was a bit unexpected. I kind of thought I had bad Chinese food the night before. But umm… that was hard, I think, having to wait for bubs to come out.	At the end of the pregnancy X felt very anxious and 'over it". She couldn't sleep properly, felt exhausted trying to walk to the end of the street. At her last antenatal consultation they hospital told her they would induce her on the Tuesday. She thought that at least they would have their baby by Tuesday. X went into labour herself on the Friday. At first X thought she had eaten bad Chinese food the night before and so the onset of labour on the Friday morning was unexpected.	LIVED BODY Sick and tired of pregnancy. -difficulty walking ?LIVED TIME Induction date puts end to pregnancy in sight. Labour began spontaneously.
13.R: So that was 9 days over or 10 days over?		
13.X: 10 days, yeah. That was hard.	X's baby was born 10 days overdue.	LIVED TIME 10 days overdue.

Appendix 11

Project Newsletter

"Mum's the Word" Research Project Newsletter

No. 1. June 2005



Dear Parents and Project Supporters,

Thank you for being part of the *"Mum's the Word": Exploring early motherhood* project. This newsletter is to keep you up to date with what has been happening with the project.

Background

While there is a lot of information available about pregnancy, childbirth and mothering, there is not a lot of information based on motherhood from the woman's perspective. New mothers are often overwhelmed and surprised by the intensity of the childbirth experience and the work involved in caring for a new baby.

Aim

This research project explores the lived experience of the early weeks of motherhood.

Research Question

The basic research question is; "What is the lived experience of early motherhood as described by women in the early weeks of motherhood?"

Participants

The project is focusing on first time mothers having a normal pregnancy. The specific criteria for participation include:

- English speaking, a first time mother, and 18 years of age or more,
- Recruited during late pregnancy, ideally between 28-34 weeks of pregnancy, and
- Normal pregnancy, not requiring any medical intervention for any complication
- Living or receiving antenatal care in Mitchell Shire (but not a MCH client of the researcher -this excludes women from Kilmore, Wandong and Heathcote Junction).

Research Design

The project involves expectant mothers being involved in interviews around three (3) key stages:

- Antenatally at 34 –38 weeks of pregnancy
- 2-3 weeks after childbirth, and
- 6-8 weeks after the birth

Participants are encouraged to write down their thoughts about their experience of early motherhood in a personal journal (diary), but this is not essential.

Collection of Information

Interviews with expectant mothers last between 40 minutes to 1-hour duration. They are recorded on audiotape and then transcribed to assist analysis.

Project Promotion

Advertising for the project has involved display of posters and pamphlets at antenatal clinics at the Kilmore & District Hospital, Seymour Memorial Hospital and local medical centres in Wallan, Broadford and Seymour.

Local midwives have supported the project by inviting expectant first time mothers to participate and distributing pamphlets.

News articles have been published in the Kilmore Free Press (6th April) and Seymour Telegraph (17th May). Press releases have been submitted to community newsletters.

Leanne has attended antenatal clinics at Kilmore (5 mornings) and Seymour (2 mornings) to invite expectant mothers to participate. Leanne has also attended antenatal classes at each hospital to invite participation.

Progress Report

1. Ten participants have offered to participate in the project. Another five further participants are still required.

2. One participant has completed all three (3) interviews and submitted her journal for copying.

3. Three further participants have completed the antenatal interview and are expecting their babies to be born soon.

4. Other participants are expecting their babies to arrive in July (2), August (2), Sept (1), and October (2).

"Mum's the Word" Research Project Newsletter

No. 1. June 2005

Journal Writing

Most people are not used to writing in a diary or journal. If you are interested in giving it a try in this project these hints may help:

- You don't need to write something everyday.
- Just write when you are thinking about something or you feel you have something to say. A couple of times a week would be terrific, but something now and again would be great.
- The basic question is: *What is being a mother like for you at this time?*
- I am interested in what is important to you: how you are feeling, what you are thinking. I would like to learn as much as possible about *your* experience of being a mother. There are no right or wrong answers, just *your* story and *your* experience of early motherhood.

Please don't be concerned if writing in a journal is not your kind of thing. I would encourage you to think about giving it a try –anything you write will be important to the project as it adds another aspect to your story. If you don't want to write in the journal I will still very much appreciate you talking with me in the interview. *The interview information is the core of the project.*

Project Findings

The information collected in the project will be used to help women and their families understand and better anticipate the experience of early motherhood. The information will also be used to provide health professionals with new information about women's experiences of early motherhood.

Reports of the completed project will be distributed to the local hospitals, General Practitioners, the Mitchell Maternal and Child Health Service, and other local agencies that work with young families. The findings of the research will also be reported in professional and parenting journals. Confidentiality and anonymity will be maintained at all times.

Funding of Project

The Australian Nursing Federation Annual Research Grant has assisted funding of this project. Additional funding is currently being sought.

Other Activities

Leanne presented a paper at the National Conference for Maternal, Child and Family Health Nurses on 30th April 2004. The paper was called: 'Perspectives on Motherhood" and reviewed recent research findings about early motherhood.

Acknowledgement and Thank You to:

- Women who have agreed to share their experience of being a mother.
- Midwives at the Kilmore and Seymour Hospitals who have been promoting the project via antenatal clinics and antenatal classes.
- The Directors of Nursing at the Kilmore and Seymour Hospitals, and local General Practitioners for supporting the project and displaying posters and flyers.
- Mitchell Shire Council for providing support and allowing leave to complete the fieldwork.

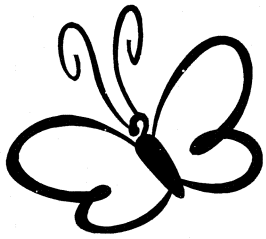
Tips for Expectant and New Parents

- Enlist some practical help for the early days of parenting.
- Prepare a list people you can call on if you need some extra emotional support.
- Learn about a few strategies to help your baby with sleep and settling. The local Maternal and Child Health centers have books or videos on settling babies available to borrow.
- Put the Maternal & Child Health Line 24 hour phone advice number to near your phone: Tel 13 22 29
- Think about how you could plan some extra rest times so both parents can avoid getting overtired with the inevitable disturbed nights. (e.g. sleep-in later, lunch time siesta, early nights).
- Identify some tasks that you would be happy to accept offers of help with (e.g.: meal, ironing, vacuuming, etc).
- Say 'yes' to offers of help.

For comments or further information contact Leanne Sheeran (Midwife, MCH Nurse and PhD student) on Mob: 0405 537 808, or email: sheeran@ssc.net.au.

"Mum's the Word" Research Project Newsletter

No. 2. July 2005



Dear Parents and Project Supporters,

Thank you for being part of the *"Mum's the Word": Exploring early motherhood* project. This newsletter is to keep you up to date with what has been happening with the project.

Background

The data collection phase of this project commenced February 2005, and it is expected that the final interview will be completed February 2006. Leanne Sheeran, a local maternal and child health nurse and midwife is completing this research project as part of a PhD in maternal and child health.

Research Question

The basic research question is: "What is the lived experience of early motherhood as described by women in the early weeks of motherhood?"

Participants

The project is focusing on first time mothers having a normal pregnancy. Women aged 18 years of age or over, and living or accessing antenatal care in the Mitchell Shire meeting theses criteria are invited to participate. Unfortunately, women who will be potential clients of the researcher are excluded (this is women from Kilmore, Wandong and Heathcote Junction areas where Leanne works). If you know any expectant first time mothers that may be interested in the project, please encourage them to contact me for further information.

Research Design

As discussed previously the project involves women being involved in interviews around three (3) key stages:

- Antenatally at 34 –38 weeks of pregnancy
- 2-3 weeks after childbirth, and
- 6-8 weeks after the birth

Participants are encouraged to write down their thoughts about their experience of early motherhood in a personal journal (diary), but this is not essential. Many people are not used to writing in a diary or journal. If you don't want to write in the journal I will still very much appreciate you talking with me in the interviews. *The interview information is the core of the project.*

Project Promotion

- Posters and pamphlets are displayed at antenatal clinics at the Kilmore & District Hospital, Seymour Memorial Hospital and local medical centres in Wallan, Broadford and Seymour.
- Local midwives have supported the project by distributing pamphlets and inviting expectant first time mothers to participate
- News articles were published in the Wallan Whistle and the Puckapunyal Boomerang, and previously in the Kilmore Free Press and Seymour Telegraph
- Antenatal Clinics have been attended nine (9) times. Leanne visited clinics at Kilmore (6 mornings) and Seymour (3 mornings) to invite expectant mothers to participate.
- Antenatal classes have been visited three (3) times to invite participation.

Progress Report

1. Thirteen women have offered to participate in the project. Another two (2) further participants are still required.
2. Two participants have completed all three (3) interviews.
3. Eight (8) participants have completed the antenatal interview. Four women have had their babies and completed the second interview.
4. Other participants are expecting their babies to arrive in July (2), August (2), Sept (1), and October (3) and Dec (1).

Collection of Information

Fourteen (14) interviews have been completed (target = 45). The interviews that have taken place so far generally last between 40 minutes to 1-hour duration. They were recorded on audiotape and then transcribed to assist analysis.

Funding of Project

The Australian Nursing Federation Annual Research Grant (2005) has assisted funding of this project. Additional funding is currently being sought.

"Mum's the Word" Research Project Newsletter No. 2. July 2005

Journal Writing

If you are interested in giving the diary / journal a try in this project these hints may help:

- *It doesn't matter if you just write something every few days. Writing when you think about something or you feel you have something to say is fine.*
- *I would like to learn as much as possible about your experience of being a mother. There are no right or wrong answers, just your story and your experience of early motherhood.*
- *Describing a situation or scene can be a good way to capture a picture of what being a mother is like for you, at a moment in time.*
- *Sometimes it can be hard to put thoughts or feelings into words.*
- *Is there any particular music or*

I would encourage you to think about making some notes in the journal –anything you write will be important to the project as it adds another aspect to your story.

After the third interview (approximately 6-8 weeks after the birth) I will borrow your journal for copying to allow inclusion in the study data. It will remain totally confidential with the researcher, and I will promptly return it for you to keep.

Other Activities

Leanne visited an Exhibition held at the Bright Art Gallery early July. The exhibition was called *Beyond the Myth: The Realities of Motherhood.* The exhibition expressed and documented real motherhood experiences of rural women from the Hume region. It used stories, photographs and poetry to celebrate the diversity of early motherhood experiences. It offered a deep and honest insight into the experience of early motherhood. The material displayed included 'the good, bad and the ugly', challenging public perceptions of motherhood. There were two pieces that were particularly interesting. The first photograph revealed an image of a disheveled sleepy mother in flannelette pyjamas and messed up hair breastfeeding a baby in the early hours of the morning- not what you see in glossy magazines. Another whimsical photograph showed a mother pegging out hundreds of disposable nappies on a rotary clothesline, while a baby sat in a washing basket at her feet.

Acknowledgement and Thank You to:

- Women who have agreed to share their experience of being a mother.
- Midwives at the Kilmore and Seymour Hospitals who have been promoting the project via antenatal clinics and antenatal classes.
- The Directors of Nursing at the Kilmore and Seymour Hospitals, and local General Practitioners for supporting the project and displaying posters and flyers.
- Mitchell Shire Council for providing support and allowing leave to complete the fieldwork.

Tips for Expectant and New Parents

- Put a list of emergency and resource numbers next to your home phone and into your mobile phone e.g. local hospital, local GP, maternity services, and 24 hr Maternal & Child Health Line (13 22 29).
- Use your answering machine to take messages when you are busy or catching up on some sleep or having an afternoon rest.
- Place a "Mother and Baby Sleeping" sign at your front door when you are resting or sleeping. If you also leave out a notepad & pen unexpected visitors can leave you a message and you can arrange to contact them at another time.
- Make sure your house or property number is clearly displayed so your house can be easily found by services such as the domiciliary midwife, MCH nurse and particularly emergency services.

For comments or further information, or to share your "tips" contact Leanne Sheeran (Midwife, MCH Nurse and PhD

"Mum's the Word" Research Project Newsletter

No. 3. August 2005

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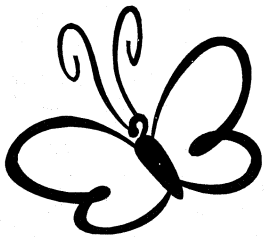


Dear Parents and Project Supporters,

Thank you for being part of the *"Mum's the Word": Exploring early motherhood* project. This newsletter is to keep you up to date with what has been happening with the project.

Background

Leanne Sheeran, a local maternal and child health nurse and midwife is completing this research project as part of a PhD in maternal and child health.

The data collection phase of this project commenced in February 2005, and it is expected that the final interview will be completed in February 2006. Details of the project are noted over the page.

Progress Report

1. Fourteen women have offered to participate in the project. Another one (1) participant is still required.
2. Five participants have completed all three (3) interviews.
3. Nine (9) participants have completed the initial antenatal interview. Seven women have had their babies and completed the second interview.
4. Other participants are expecting their babies to arrive in Sept (1), and October (4) and Dec (1).

Collection of Information

Twenty one (21) interviews have been completed (target = 45). The interviews that have taken place so far generally last between 40 minutes to 1-hour duration. They are recorded on audiotape and then transcribed to assist analysis.

Funding of Project

The Australian Nursing Federation Annual Research Grant (2005) has assisted funding of this project. Additional funding is currently being sought.

Journal Writing

Keeping a diary / journal is a supplementary feature of this research design. Participants are encouraged to think about making some notes in the journal about their experiences of being a mother. Anything you write will be important to the project as it adds another aspect to your story.

If you are interested in giving the diary / journal a try in this project these hints may help:

- *The idea of the diary / journal is to learn as much as possible about your experience of being a mother. There are no right or wrong answers, just your story and your experience of early motherhood.*
- *How do you feel about any changes in your body, emotions or relationships that are linked with being a mother?*
- *Describing a situation or scene can be a good way to capture a picture of what being a mother is like for you, at a moment in time.*
- *You don't need to write something every day. Writing when you think about something or you feel you have*

After the third interview (approximately 6-8 weeks after the birth) I will borrow your journal for copying, so it can be included in the study data. All information collected for the study will be kept confidential and any identifying details will be removed. The journal will be returned to you promptly for you to keep.

Other Activities

I wrote in the last newsletter about the exhibition I visited at the Bright Art Gallery early July. The exhibition was called *Beyond the Myth: The Realities of Motherhood.* The exhibition expressed and documented real motherhood experiences of rural women from the Hume region. It used stories, photographs and poetry to celebrate the diversity of early motherhood experiences. There were many photographs that were particularly interesting. One photograph was a close up of a kitchen sink area

covered with a myriad of bottles, teats, caps, rings and sterilising equipment involved in feeding a baby formula. It was an everyday picture that showed all the washing, cleaning and sterilising involved in looking after a baby's feeding needs. Another photograph depicted a couple of mothers hanging from a rotary clothesline with the washing. I think it was called "Hung out to Dry". This photograph seemed to also capture the wrung out feeling that sometimes relates to the huge workload in washing that occurs with having a baby in the home.

Tips for Expectant and New Parents

- Acknowledge unsolicited advice – but just use what you feel may be helpful for you and your baby.
- It is okay to leave jobs for tomorrow or later in the week. Time with your baby and partner is more important.
- Allocate some time each day to do something you enjoy, or something for yourself.
- Allocate some time each day to nurture your relationship with your partner as a couple.

BACKGROUND DETAILS OF PROJECT

Research Question

The basic research question is: "What is the lived experience of early motherhood as described by women in the early weeks of motherhood?"

Participants

The project is focusing on first time mothers having a normal pregnancy. Women aged 18 years of age or over, and living or accessing antenatal care in the Mitchell Shire meeting theses criteria are invited to participate. Unfortunately, women who will be potential clients of the researcher are excluded (this is women from Kilmore, Wandong and Heathcote Junction areas where Leanne works). If you know any expectant first time mothers that may be interested in the project, please encourage them to contact me for further information.

Research Design

As discussed previously the project involves women being involved in interviews around three (3) key stages:

- Antenatally at 34 –38 weeks of pregnancy
- 2-3 weeks after childbirth, and
- 6-8 weeks after the birth

Participants are encouraged to write down their thoughts about their experience of early motherhood in a personal journal (diary), but this is not essential. Many people are not used to writing in a diary or journal. If you don't want to write in the journal I will still very much appreciate you talking with me in the interviews. *The interview information is the core of the project.*

Project Promotion

- Posters and pamphlets are displayed at antenatal clinics at the Kilmore & District Hospital, Seymour Memorial Hospital and local medical centres in Wallan, Broadford and Seymour.
- Local midwives have supported the project by distributing pamphlets and inviting expectant first time mothers to participate
- News articles were published in the Wallan Whistle and the Puckapunyal Boomerang, and previously in the Kilmore Free Press and Seymour Telegraph
- Antenatal Clinics have been attended nine (9) times. Leanne visited clinics at Kilmore (6 mornings) and Seymour (3 mornings) to invite expectant mothers to participate.
- Antenatal classes have been visited four (4) times to invite participation.

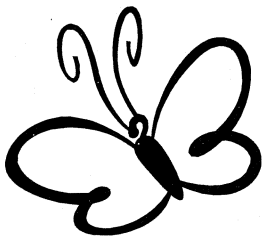
Acknowledgement and Thank You to:

- Women who have agreed to share their experience of being a mother.
- Midwives at the Kilmore and Seymour Hospitals who have been promoting the project via antenatal clinics and antenatal classes.
- The Directors of Nursing at the Kilmore and Seymour Hospitals, and local General Practitioners for supporting the project and displaying posters and flyers.
- Mitchell Shire Council for providing support and allowing leave to complete some of the fieldwork.

For comments or further information, or to share your "tips" contact Leanne Sheeran (Midwife, MCH Nurse and PhD

"Mum's the Word" Research Project Newsletter

No. 4. September 2005



Dear Parents and Project Supporters,
Thank you for being part of the *"Mum's the Word": Exploring early motherhood* project. This newsletter is to keep you up to date with what has been happening with the project.

Background

Leanne Sheeran, a local maternal and child health nurse and midwife is completing this research project as part of a PhD in maternal and child health.

The data collection phase of this project commenced in February 2005, and it is expected that the final interview will be completed in February 2006. Details of the project are noted over the page.

Progress Report

1. Eight (8) participants have completed all three interviews. For the purposes of the study these women will be known as: Xerri, Angela, Jess, Sarah, Rose, Christie, Gail and Ursula.
2. Another four (4) women have completed the antenatal interview and are waiting for their babies to be born.
3. Participants are expecting their babies to arrive in Sept (1), and October (3) and Dec (1).
4. Another two participants are still required. *Do you know anyone fitting the criteria who may be interested?*
    - First time mum, 18 years or older
    - Essentially normal pregnancy
    - Living or attending antenatal care locally (except not from Kilmore or Wandong).

    If so, please pass on my contact number so they can call me for further information.

Collection of Information

A total of twenty eight (28) interviews had been completed at the end of September (Target =45). The interviews generally last between 40 minutes and one-hour duration. They are recorded on audiotape and then transcribed to assist analysis.

Other Activities

I was invited to make a presentation about this project to a nursing research conference. The 2-day conference was organised by the Deans of Nursing from universities in Victoria and Tasmania and was held 25-26 September at the Australian Catholic University's Melbourne campus.

My presentation was allocated 30 minutes and included the reasons for the study, the research design and some preliminary findings. The audience for the presentation was made up of midwives, nurses, university lecturers and Professors of Nursing and Midwifery. The group had several questions about the project and offered helpful suggestions about other references to look at. My supervisor Professor Gay Edgecombe (RMIT University) assisted and encouraged me in preparing the 'talk' and was pleased with how it went.

It was helpful to have midwives and nurses provide feedback about the study and to discuss women's experiences of early motherhood. It was also very interesting to hear about research being planned or in-progress by other midwives and maternal and child health nurses.

Tips for Expectant and New Parents

- Rest when your baby sleeps. If you can't sleep in the daytime perhaps lie down and listen to your favourite music or browse through a magazine.
- If you are rested it is a little easier to cope with the inevitable baby care and feeds late at night, in the middle of the night and early morning.
- Sleep and Settling: The Maternal and Child Health service offers information and discussion sessions on sleep and settling in 0-1 year old children *every fortnight* in the shire. Venues alternate between Seymour, Kilmore and Wallan. Phone your local MCH nurse or the Shire for details on Tel: 5734 6253.

Funding of Project

The Australian Nursing Federation Annual Research Grant (2005) has assisted funding of this project. Additional funding is currently being sought.

"Mum's the Word" Research Project Newsletter No. 4. September 2005

Acknowledgement and Thank You to:

- Women who have agreed to share their experience of being a mother.
- Midwives at the Kilmore and Seymour Hospitals who have been promoting the project via antenatal clinics and antenatal classes.
- The Directors of Nursing at the Kilmore and Seymour Hospitals, and local General Practitioners for supporting the project and displaying posters and flyers.
- Mitchell Shire Council for providing support and allowing leave to complete some of the fieldwork.

Advertisement: Baby Massage course

A 4-week baby massage course will start at Kilmore MCH centre (no charge) Tuesdays 3pm-4pm from 18th Oct. Bookings essential, Tel: 5782 1098

BACKGROUND DETAILS OF PROJECT

[Reprinted]

Research Question

The basic research question is: "What is the lived experience of early motherhood as described by women in the early weeks of motherhood?"

Participants

The project is focusing on first time mothers having a normal pregnancy. Women aged 18 years of age or over and living or accessing antenatal care in the Mitchell Shire are invited to participate. Unfortunately, women who will be potential clients of the researcher are excluded (this is women from Kilmore, Wandong and Heathcote Junction areas where Leanne works).

Research Design

As discussed previously the project involves women being involved in interviews around three (3) key stages:

- Antenatally at 34 –38 weeks of pregnancy
- 2-3 weeks after childbirth, and
- 6-8 weeks after the birth

Participants are encouraged to write down their thoughts about their experience of early motherhood in a personal journal (diary), but this is not essential.

Many people are not used to writing in a diary or journal. If you don't want to write in the journal I will still very much appreciate you talking with me in the interviews. *The interview information is the core of the project.*

Journal Writing

Keeping a diary / journal is a supplementary feature of this research design. Participants are encouraged to think about making some notes in the journal about their experiences of being a mother. Anything you write will be important to the project as it adds another aspect to your story.

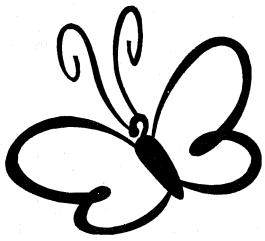
If you are interested in giving the diary / journal a try in this project these hints may help:

- You don't need to write something every day. Writing when you think about something or you feel you have something to say is fine.
- Sometimes it can be hard to start writing. Try jotting down some ideas to start yourself off, you may be surprised how it flows.
- How do you feel about any changes in your body, emotions or relationships that are linked with being a mother?
- The idea of the diary / journal is to learn as much as possible about your experience of being a mother. There are no right or wrong answers, just your story and your experience of early motherhood.

After the third interview (approximately 6-8 weeks after the birth) I will borrow your journal for copying, so it can be included in the study data. All information collected for the study will be kept confidential and any identifying details will be removed. The journal will be returned to you promptly for you to keep.

For comments or further information, or to share your "tips" contact Leanne Sheeran (Midwife, MCH Nurse and PhD

"Mum's the Word" Research Project Newsletter No. 5. Oct / Nov 2005



Dear Parents and Project Supporters,
Thank you for being part of the *"Mum's the Word": Exploring early motherhood* project. This newsletter is to keep you up to date with what has been happening with the project.

Background
Leanne Sheeran, a local maternal and child health nurse and midwife is completing this research project as part of a PhD in maternal and child health.

The data collection phase of this project commenced in February 2005, and it is expected that the final interview will be completed in February 2006.

Good News
1. Leanne has received a scholarship from the Royal College of Nursing Australia called the *2006 Bequest Fund for Research* to assist with the *Mum's the Word: Exploring early motherhood project.* This scholarship is administered by the Royal College of Nursing Australia, which is based in Canberra. The funds from this scholarship will cover almost 50 per cent of the research costs. This will be of great assistance! It will supplement an earlier grant received from the Australian Nursing Federation (Vic) in December 2004.

2. The Mitchell Shire has approved an application Leanne has made for one day per week of unpaid leave during 2006. This will enable her to have another day to work on the analysis of all the interview data collected. This means Leanne will work three (3) days each week in maternal and child health and have the rest of the week available for *'Mum's the Word'.*

Progress Report
1. Nine (9) participants have completed all three interviews.
2. Another three (3) women have given birth and completed the two week interview.
3. One final participant is expecting her baby to arrive in December.

Collection of Information
A total of thirty three (33) interviews had been completed at the end of November. The interviews generally last between 45 minutes and 90 minutes duration. They are recorded on audiotape and then transcribed to assist analysis.

Target Participants Achieved
As the requirement of 10-15 participants has been met, no further participants will be needed.

The amended number of target interviews with a total of 13 participants will be 39 interviews. The remaining six (6) interviews are scheduled for December –February 2006.

Why a Small Number of Participants?
Why Interviews?
Some research projects collect quantitative data (or data that can be counted) and have large numbers of participants to enable generalisations to be made. This study uses a qualitative approach and focuses on in depth exploration of women's experiences. In this type of study fewer participants are required as the focus is on the topic being explored in greater depth.

A quantitative study might involve 100 women and ask participants to answer a questionnaire by ticking boxes. For example:

Q.1. "What is being a mother like for you?

- ☐ Very good
- ☐ Good
- ☐ Mostly good
- ☐ Sometimes difficult
- ☐ Difficult
- ☐ Very Difficult

The *"Mum's the Word"* study uses in depth interviews with women at three key stages of early motherhood to explore women's experiences of early motherhood. This has enabled a deeper level of information about women's experiences of early motherhood to be collected. When women are asked about their experiences of early motherhood the information they share can be followed up with further questions to obtain a more detailed description of their experience. Women's stories, the thoughts and experiences women share, and the examples they use to illustrate their comments add a great richness to the information obtained.

Participants have been fantastic in the information they have shared with this project. Each interview produces an average of 10 pages of transcribed conversation. The preliminary analysis of one interview produces about thirty pages of typed data!

Other Activities

In October Leanne made a presentation about this project to the team of maternal and child health nurses at the Mitchell Shire. Leanne outlined the design of the study, its progress, and some preliminary information about findings so far. During the one-hour session the maternal and child health nurses provided some very helpful feedback to the project. It was also useful to discuss women's experiences of early motherhood and how as health workers we can better support women.

PHOTOS ? - Do any participating families have any photographs they would be happy to share with the project? Any aspect of early motherhood: pregnancy onwards, positive or realistic is welcome. Baby photos also sought. Digital or film photos welcome.
*You would need to give written permission before any photograph could be included.
Please phone Leanne if you may be interested.

Tips for Expectant and New Parents

(or)

-How to survive the silly season when you're very pregnant or have a young baby-

- Make Christmas as enjoyable and as EASY AS POSSIBLE for yourself, your partner and your baby. If you still have to do any Christmas shopping try and avoid both the crowds and hot days. Shop early in the month, and preferably take someone with you to help with the parcels and/or baby.
- Avoid or minimise any obligations for Christmas. Let someone else cook Christmas dinner while you sit down or attend to your baby. Minimise travel.
- Enjoy any Christmas parties or functions. Skip the ones that are tedious or a trial.
- Have some time alone with your partner. You are parents but you both still have an adult relationship to maintain.
- Find a good baby sitter – perhaps grandparents or aunties and uncles rather than teenyboppers for young babies.
- Get plenty of sleep. Plan some rest times around the extra social activities so you don't get too frazzled or become 'unstuck'.
- If you are rested it is a little easier to cope with baby care and the inevitable feeds and nappy changes late at night, in the middle of the night and early morning; (not to mention the parties!)
- Rest when your baby sleeps. If you can't sleep in the daytime perhaps lie down and listen to your favourite music or browse through a magazine.
- Say no, and don't feel guilty.
- Keep everything simple.

Acknowledgement and Thank You to:

- Women who have generously participated and shared their experience of being a mother.
- Midwives at the Kilmore and Seymour Hospitals who have promoted the project via antenatal clinics and antenatal classes.
- The Directors of Nursing at the Kilmore and Seymour Hospitals, and local General Practitioners for supporting the project and displaying posters and flyers.
- The Mitchell Shire Maternal and Child Health Nurses' team for ongoing feedback and support.
- Mitchell Shire Council for providing support and allowing leave to complete some of the fieldwork.
- Professor Gay Edgecombe and Dr. Anthony Welch of the Division of Nursing and Midwifery at RMIT University, who provide supervision of the research.

Acknowledgement and Thanks to the Funding Bodies

- The Australian Nursing Federation for providing the *ANF Annual Research Grant* (December 2004).
- The Royal College of Nursing Australia for provision of the *2006 Bequest Fund for Research Scholarship.*

"Mum's the Word" Research Project Newsletter

No. 6. Dec 05- Feb 06

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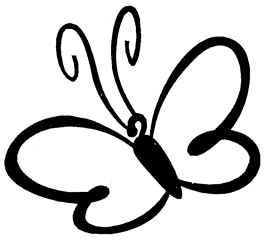


Dear Parents and Project Supporters,

Thank you for being part of the *"Mum's the Word": Exploring early motherhood* project. This newsletter is to keep you up to date with what has been happening with the project.

Background

Leanne Sheeran, a local maternal and child health nurse and midwife is completing this research project as part of a PhD in maternal and child health.

More Hours for Project

Leanne will commence working on the project two days per week from 22nd February 2006, following approval from the Mitchell Shire Council for her to take one day per week of unpaid leave. This means Leanne will work three (3) days each week in maternal and child health and have the rest of the week available for *'Mum's the Word'*.

Progress Report

1. Twelve (12) participants have completed all three interviews.
2. The final participant has completed the first and second interviews. Her final interview is scheduled for February.

Collection of Information

A total of thirty eight (38) interviews have been completed. The interviews generally lasted between 45 minutes and 90 minutes duration. They were recorded on audiotape and then transcribed to assist analysis. As the requirement of 10-15 participants has been met, no further participants will be needed. The amended number of target interviews with a total of 13 participants is 39 interviews.

General Outcomes

- The thirteen (13) mothers involved in this study gave birth between March 2005 and January 2006.
- All women gave birth in a hospital setting, with four (4) different hospitals involved in total. These were two local hospitals as well as a metropolitan and another rural hospital.
- Nine (9) women gave birth in local hospitals, two (2) gave birth in the metropolitan hospital and one (1) had her baby at a rural hospital outside the municipality.
- A few mothers experienced complications during labour or while giving birth. These were managed in the hospitals where they delivered their babies. No one required transfer to a city maternity hospital for specialised care.
- Two (2) women had normal deliveries, nine (9) women had vaginal deliveries assisted by forceps or vacuum, and two (2) women required emergency Caesarean deliveries.
- Each participant gave birth to a single child. There were nine (9) baby girls and four (4) baby boys born. All infants were born between 37 and 42 weeks gestation and were healthy.
- Four (4) participants were able to keep a personal journal / diary to supplement the interview data about their experience of early motherhood.

Thank You to Participants

This study would not have been able to proceed without the contribution of the thirteen women who shared their stories of their experience of early motherhood.

Each mum in the study chose a pseudonym for themselves as part of maintaining confidentiality. Sincere thanks and appreciation is expressed to: Xerri, Angela, Jess, Sarah, Rose, Christie, Gail, Ursula, Bernadette, Kate, Lee-ann, Dianne and Hayley.

Becoming a mother is a significant transition and the generous commitment of these women to participate in three separate interviews enabled the data collection at key stages to be successfully completed. The information shared by these participants will be used to help women and their families understand and better anticipate the experience of early motherhood. It will also be used to provide health professionals with new information about women's experiences of early motherhood. Thank you very very much!

Data Analysis

Data Analysis has just begun. Each interview needs to be transcribed (which means typed out word for word). Analysis involves a line-by-line analysis for content and themes. Journal material will also be studied for content and themes. It is anticipated that the data analysis phase will take about nine months to complete.

Findings

The writing up phase of the study will require a substantial amount of time. The research will be submitted as a PhD thesis to RMIT University. When available, the findings of the research will be distributed to participants and associated agencies. As discussed initially with all participants, it is anticipated that the study findings will also be published in professional journals and popular press, as well as disseminated via conference presentations.

A Picture Tells A Thousand Words

PHOTOS ? - Do any participating families have any photographs they would be happy to share with the project? Any aspect of early motherhood: pregnancy onwards, positive or realistic is welcome. Baby photos also sought. Digital or film photos welcome.

*You would need to give written permission .
*Only pseudonyms would be used.

Please phone Leanne if you may be interested.
Telephone: 0405 537 808

Tips for New Parents

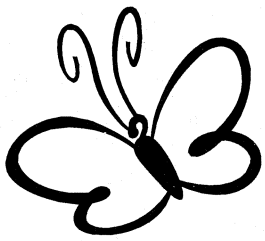
- How are you feeling in yourself? Your Maternal and Child Health Nurse can advise about your health and wellbeing as well as your baby's well being. If it is taking a little longer than you expected to recover from the birth, if you have any ongoing health issues, or you just feel a bit flat- talk with your GP or MCH Nurse. There are a range of options and strategies available to help.
- Looking after yourself as a person is really important. Put some time aside each day to do something you want to do. It might be to read a magazine or book, to do something nurturing (eg. A long bath, apply some hand lotion), spend some time in the fresh air, do some exercise– whatever is pleasant for you.
- Plan a regular or even occasional break for yourself. Grandparents or other family members are often happy to assist with childcare. As babies get older they can usually manage short periods away from their parents and parents usually feel recharged after even a short break.
- Spend some time working on your relationship with your partner. Maintaining your relationships as an adult strengthens and supports your ability to parent.
- Might you be returning to work? Discuss local options with your Maternal and Child Health Nurse. Book in for crèche if you haven't yet done so. It is a good idea to visit childcare centres that are either local to your home or workplace. Family Day Care is a very good alternative for babies requiring care. For further information telephone the Family Day Care office at the Shire and speak with a Field Worker (Tel: 5734 6200).
- Did you know that the Mitchell Shire Council Library has a range of parenting magazines are available for loan? The MCH Service also has some books, booklets, and videos on topics like sleep and settling, postnatal depression, breastfeeding and toddler behaviour that can be borrowed.

Other Acknowledgement and Thank You to:

- Midwives at the Kilmore and Seymour Hospitals who have promoted the project via antenatal clinics and antenatal classes.
- The Directors of Nursing at the Kilmore and Seymour Hospitals, and local General Practitioners for supporting the project and displaying posters and flyers.
- The Mitchell Shire Maternal and Child Health Nurses' team for ongoing feedback and support.
- Mitchell Shire Council for providing support and allowing leave to complete some of the fieldwork.
- Professor Gay Edgecombe and Dr. Anthony Welch of the Division of Nursing and Midwifery at RMIT University, who provide supervision of the research.

Acknowledgement and Thanks to the Funding Bodies

"Mum's the Word" Research Project Newsletter No. 7. Dec 2006



Dear Parents and Project Supporters,
Thank you for being part of the *"Mum's the Word": Exploring early motherhood* project. This newsletter provides an update about the project.

Background
This research project is being undertaken by Leanne Sheeran, a local maternal and child health nurse and midwife as part of a PhD in maternal and child health. The final field interview for the project was completed in Feb 2006.

Collection of Information
Thirteen (13) participants participated in three interviews, with a total of 39 interviews completed. The interviews generally lasted between 45 minutes and 90 minutes duration. They were recorded on audiotape and then transcribed to assist analysis.

Data Analysis
Data Analysis has been in progress all year. This involves word by word transcription of each interview and a line-by-line analysis for content and themes. Journal material is also being studied for content and themes. So far, the information relating to participants' experience of pregnancy and the early weeks after the birth has been analysed. Data relating to participant's experiences of labour and birth and the 8 week interview will be analysed next. It is hoped that the data analysis can be completed fully by April 2007.

Findings
The writing up phase of the study usually requires a lot of time. The research will initially be submitted as a PhD thesis to RMIT University and then distributed in a summary/report form to participants and associated agencies. As discussed initially with all participants, it is anticipated that the study findings will also be published in professional journals and popular press, as well as disseminated via conference presentations. Anonymity and confidentiality will be ensured at all times by removing any details which could identify participants.

Key Themes Emerging
The Lived Experience of Pregnancy

- The transition from woman to pregnant mother was a significant change for participants, and most reported seeing life differently during their pregnancy.
- Pregnancy involved a lot of waiting. For many this involved waiting to share the news of the pregnancy, learning about birthing and mothering, getting everything ready for the new baby at home and waiting for the baby to arrive.
- Pregnancy also involved a lot of contemplation and wondering. A number of participants experienced grief and loss either around the time their baby was conceived or during their pregnancy and wondered about the connectedness of life and death. Women also wondered about the labour and birth, about their baby and about themselves as a mother. For example: When will the baby come? Will I be able to cope with the labour? Will I be able to look after a baby? Will I be able to work out why it is crying?
- Most participants reported that labour was the hardest thing they had ever done.

Learning to Feed

- The experience of learning to feed was a key theme of the postnatal interviews. All participants began breastfeeding their infants, however most described difficulties initially with latching their baby to feed, or with tender, grazed or cracked nipples. Most women were quite surprised by how difficult they found learning to breastfeed.
- Some women weaned in the early weeks because of concerns about low milk supply and unsettled infants. Several commented that they liked knowing how much formula their baby was taking when bottle feeding. Those who continued breastfeeding generally felt it was the best thing for their baby and that it became much easier after the early weeks.
- By eight (8) weeks most breastfeeding problems were resolved and 61% of participants were still breastfeeding. The 39% who had stopped breastfeeding were well established with formula feeding.

Learning to Mother

- Learning to mother was a strong theme in the postnatal interviews. Almost all participants described early motherhood as a being a lot harder than expected. Angela

mused: *'Maybe I expected champagne and roses. I got dirty nappies and a crying baby instead.' (laughs)*

- Early motherhood was a very emotional experience for a number of participants as they adapted to physical recovery from the birth, lack of sleep, and learning how to care for a newborn baby.
- The experience of 'not knowing' about aspects of looking after their baby was difficult and participants reported that learning to mother was made more difficult by the uncertainty and confusion that was present in the early days, and the conflicting advice they received. Many participants related that *'the first week was very difficult'.*
- Managing infant crying and living with crying were closely intertwined with women's emotions and the quandary of 'not knowing' what was wrong with the baby.
- Many women participating reported in the 2 week interview that they felt very distressed themselves when their baby cried.
- After a few weeks most participants said that they could identify several of their baby's cries such as being hungry or tired. Women reported that as they learnt to distinguish their baby's cries they were able to respond more appropriately to their baby's communications and needs.
- Most women reported feeling more confident and coping better as the weeks progressed. Rose summed it up: *"I feel happy because my emotions are a lot more settled... and I feel like I know what I'm doing and it's so much easier."*

Conference Presentations

Some of the preliminary findings have been presented at conferences attended by nurses, midwives, maternal and child health nurses, mother craft nurses and university staff. Presentations have been made at the following conferences:

- Mitchell Shire Breastfeeding Seminar (May 2006).
- Deans of Nursing and Midwifery Collaborative Research School held at Melbourne University (Sept 2006).
- QEC 4th National Conference Early Childhood: Evidence into Practice held at Melbourne University (Nov 2006).

Thank You to Participants

Thank you again to all the participants who shared their stories of their experience of early motherhood. The information provided will be used to help women and their families understand and better anticipate the experience of early motherhood. It will also be used to provide health professionals with new information about women's experiences of early motherhood. Thank you very very much!

A Picture Tells A Thousand Words

PHOTOS ?

Thank you to the families who have offered or contributed photographs to the project.

Do any other participating families have any photographs they would be happy to share with the project? Any aspect of early motherhood: pregnancy onwards, positive or realistic is welcome. Photos of young babies are also sought. Digital or film photos welcome.

*You would need to give written permission .
*Only pseudonyms would be used.

Please phone Leanne if you may be interested.
Telephone: 0405 537 808

Other Acknowledgement and Thank You to:

- The Directors of Nursing at the Kilmore and Seymour Hospitals, and local General Practitioners for supporting the project and displaying posters and flyers. Midwives at both hospitals who promoted the project.
- Mitchell Shire Council for providing support and allowing leave to complete some of the fieldwork, and the Maternal and Child Health Nurses' team for ongoing feedback and support.
- Professor Gay Edgecombe and Dr. Anthony Welch of the Division of Nursing and Midwifery at RMIT University, who provide supervision of the research.

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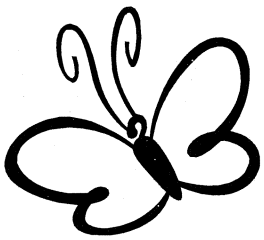
"Mum's the Word" Research Project Newsletter No. 8. Dec 2007



Dear Parents and Project Supporters,
Thank you for being part of the *"Mum's the Word": Exploring early motherhood* project. This newsletter provides an update about the project.

Background
This research project is being undertaken by Leanne Sheeran, a local maternal and child health nurse and midwife as part of a PhD in maternal and child health.

Collection of Information
Thirteen (13) participants each participated in three interviews. Interviews were held in the last 6 weeks of pregnancy, 2-3 weeks after childbirth and when the baby was about 8 weeks old. The interviews generally lasted between 45 minutes and 90 minutes duration and they were recorded on audiotape. Four (4) participants also kept journals about their experience of early motherhood during the study period.

Data Analysis
Data Analysis has been in progress all year and is almost completed. This has involved word by word transcription of each interview and a line-by-line analysis for content and themes. Journal material has also been studied for issues and themes. Analysing the data has been a massive task as there were over 40 hours of interview material collected. The information relating to participants' experience of pregnancy, labour and birth, and the early weeks after the birth has been analysed. Some issues will need deeper analysis.

Findings
The writing up phase of a study always requires a lot of time. The research will initially be submitted to RMIT University as a PhD thesis. Following this the next task will be to write up the findings in a format that can be reported to midwives, MCH nurses, hospitals and clinics, and used to help women understand the range of experiences that are involved in becoming a mother.

As initially discussed with all participants, it is anticipated that the study findings will also be published in professional journals and popular press. They will also be presented at health conferences. Confidentiality and the anonymity of participants will be maintained by removing any details which could identify participants.

Key Themes Emerging

Labour and Birth

- The 13 participants gave birth between March 2005 and January 2006.
- All participants gave birth in hospitals, with women attending four (4) different hospitals.
- For participants having a vaginal delivery the duration of labour ranged from eight (8) to 43 hours.
- The length of pregnancy ranged from 37.5 weeks to 41.3 weeks. Three (3) participants gave birth prior to 40 weeks gestation, but the other ten (10) participants had their babies at 40 weeks or later.
- Three participants had an unassisted normal delivery, eight (8) women had vaginal deliveries assisted by forceps or vacuum, and two (2) women required emergency Caesarean deliveries.
- Most participants acknowledged labour as 'the hardest thing they had ever done'.
- Participants provided some great descriptions of having contractions that will be helpful to share with first time expectant mothers.
- Participants needing a caesarean delivery had epidural or spinal anaethesia and were awake for the birth. It was very helpful to understand and record women's experiences of having a caesarean birth.
- Most participants indicated that although labour and birth or caesarean birth were difficult experiences, they would probably go through it again as 'the baby was worth it.'
- As a practicing MCH Nurse I am already integrating information from the study into work with new mothers and their families.

Conference Presentations
Some of the preliminary study findings have been presented this year at conferences attended by midwives, maternal and child health nurses, mother craft nurses and university staff. Presentations have been made at the following conferences:

- *Partnerships in Practice,* Australian Association of Maternal, Child & Family Health Nurses, 2nd National Conference held in Sydney (3-5 May 2007).
- Deans of Nursing and Midwifery Collaborative Research School held at Deakin University (Sept 2007).
- Social Determinants of Women's Health, Thai-Australia Workshop held at the Division of Nursing and Midwifery, RMIT University, Bundoora (26-27th Nov 2007).

Thank You to Participants

This study would not have been possible without participants sharing their experiences of early motherhood. The findings will be used to help women and their families understand and be more prepared for the experience of early motherhood. They will also be used to provide health professionals with new information about women's experiences of early motherhood. Thank you again to those who participated.

A Picture Tells A Thousand Words

PHOTOS ?

Thank you to the families who have offered or contributed photographs to the project.

Do any other participating families have any photographs they would be happy to share with the project? Any aspect of early motherhood: pregnancy onwards, positive or realistic is welcome. Photos of young babies are also sought. Digital or film photos welcome.

*You would need to give written permission .
*Only pseudonyms would be used.
*Photos will not be used in any local reports.

Please phone Leanne if you can help.
Telephone: 0405 537 808

Interview Transcripts

The interview transcripts can be provided to participants, if you would like this. Please contact me by phone or email to confirm if you want a copy.

Second Babies

Several participants in this study have had their second baby. Congratulations to these families!!
I would be interested to have a chat about how you experienced becoming a mother the second time around, if anyone has the time after the holidays. (*informal*)

Project Time Line

Drafts of six (6) chapters have been completed so far, with another four chapters still to finish. Writing the project up is a slow process, but it is very interesting and worth completing carefully. My candidature at the university continues until May 2009, but I will be trying to complete the thesis by the end of 2008.

Other Acknowledgement and Thank You to:

- The Directors of Nursing at the Kilmore and Seymour Hospitals, and local General Practitioners for supporting the project and displaying posters and flyers. Midwives at both hospitals who promoted the project.
- Mitchell Shire Council for providing support and allowing leave to complete some of the fieldwork and data analysis, and the Maternal and Child Health Nurses' team for ongoing feedback and support.
- Professor Gay Edgecombe of the Division of Nursing and Midwifery at RMIT University, and Dr. Anthony Welch, Queensland University of Technology, who provide supervision of the research.

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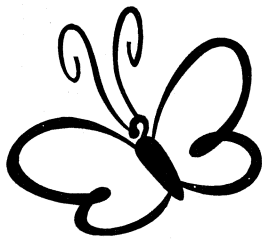

Dear Parents and Project Supporters,
Thank you for being part of the *"Mum's the Word": Exploring early motherhood* project. This newsletter provides an update about the project.

Background
This research project is being undertaken by Leanne Sheeran, a local maternal and child health nurse and midwife as part of a PhD in maternal and child health. It commenced July 2004 and should be completed by mid 2009. The research project explores women's experiences of early motherhood.

Collection of Information
Thirteen (13) participants each participated in three interviews. Interviews were held in the last 6 weeks of pregnancy, 2-3 weeks after childbirth and when the baby was about 8 weeks old. The interviews generally lasted between 45 minutes and 90 minutes duration and they were recorded on audiotape. Four (4) participants also kept journals about their experience of early motherhood during the study period.

Data Analysis
Analysing the data has been a massive task as there were over 40 hours of interview material collected. The information relating to participants' experience of pregnancy, labour and birth, and the early weeks after the birth has been analysed and data analysis has now been completed. This has involved word by word transcription of each interview and a line-by-line analysis for content and themes. Journal material has also been studied for issues and themes.

Findings
The preliminary research findings have been presented at several health conferences 2006-08.. The research will be formally submitted as a PhD thesis to RMIT University. Following this the next task will be to write up the findings in a format that can be reported to midwives, MCH nurses, hospitals and clinics, and used to help women understand the range of experiences that are involved in becoming a mother.

As initially discussed with all participants, it is anticipated that the study findings will also be published in professional journals and popular press. Confidentiality and the anonymity of participants will be maintained by removing any details which could identify participants.

Key Themes Emerging

Breastfeeding
All participants began breastfeeding and were breastfeeding their babies on discharge from hospital.

All participants experienced some difficulties with breastfeeding initially. (See table for summary).

Summary of Breastfeeding Experiences

Number (N=13)	Difficulty
13	Latching baby at breast
13	Tender nipples and / or Grazed nipples
13	Concerns about insufficient supply
2	Cracked and Bleeding nipples
1	Mastitis
2	Thrush infection
6	Negative advice from mothers / mothers-in-law & friends

Of 13 participants, 8 were breastfeeding at 8 weeks, and 6 continued to breastfeed for 6 months or more.

Reasons for weaning given by participants in the early weeks centred on concerns about insufficient supply or difficulty latching the baby comfortably.

Some mothers felt happier bottle feeding as they felt they could see what their baby was drinking.

Women weaning after several months of breastfeeding did so for reasons such as persistent sore nipples or thrush infection.

Some women described initially learning to breastfeed as a very physical experience with '*great big engorged breasts [that] were massive and excruciating*' and nipples that '*were very very very sore for the first week'*.

Making sense of conflicting advice about breastfeeding was an issue for many women.

A number of women felt overwhelmed by the number of things that were happening to them in the first few days after their baby was born. Juggling IV lines, breast engorgement, sore nipples, nipple

shields, painful stitches, passing clots and learning baby care made learning to breastfeed difficult.

Women described getting help with breastfeeding from a range of sources including midwives, their mum, their sister, MCH nurse & ABA counselor.

As a practicing MCH Nurse I am already integrating information from the study into work with new mothers and their families.

Conference Presentations

Some of the preliminary study findings have been presented this year at conferences attended by midwives, maternal and child health nurses, mother craft nurses and university lecturers. Presentations have been made at the following conferences:

4 Sept 2008, 'Recruiting and Retaining Participants: A Case Study of an Early Motherhood Research Project' presented at the 4th *Collaborative Victorian and Tasmanian Dean's of Nursing and Midwifery Conference,* held at RMIT University, Bundoora, Victoria.

20 Nov 2008 'Women's Experiences of Learning to Feed' paper presented at *Reaching Out to Vulnerable Families: Achieving Better Outcomes for Children, Queen Elizabeth Centre 5th Biennial International Conference* held at the Sebel Hotel, Albert Park, Melbourne.

Thank You to Participants

Thank you to the participants who shared their experience of early motherhood. The findings will be used to help women and their families understand and be more prepared for the experience of early motherhood. They will also be used to provide health professionals with new information about women's experiences of early motherhood. Thank you again to those who participated.

Interview Transcripts

The interview transcripts can be provided to participants, if you would like this. Please contact me by phone or email if you want a copy of your transcript.

Second Babies

Several participants in this study have had their second baby. Congratulations to these families!!
I would be interested to have a chat about how you experienced becoming a mother the second time around, if anyone has the time after the holidays. (This won't form part of the study.)

A Picture Tells A Thousand Words

PHOTOS

Thank you to the families who have offered or contributed photographs to the project.

Do any other participating families have any photographs they would be happy to share with the project? Any aspect of early motherhood: pregnancy onwards, positive or realistic is welcome. Photos of young babies are also sought. Digital or film photos welcome.

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For comments or further information, contact Leanne Sheeran (Midwife, MCH

Appendix 12

Resources for Mums

SERVICE	LOCATION	CONTACT	BRIEF DESCRIPTION	SPECIAL NOTES
Family violence and sexual assault				
Lower Hume Domestic Violence Outreach Support Services for Women & Children	Murrindindi & Mitchell Shires	5784 5555	Counseling, advocacy, court support, assistance to find accommodation.	
Women's Domestic Violence Crisis Service of Victoria	Statewide	1800 015 188	24 hour telephone advice, support and referral. If you are in immediate danger, call Police on 000.	☎24
Women's Legal Resource Group (Victoria)	Statewide	1800 133 302	Telephone advice from female lawyers; referrals; assistance to obtain Legal Aid.	
Immigrant Women's Domestic Violence Service	Statewide	9898 3145	Telephone support and some outreach in 20 languages. Uses interpreting services when necessary.	
Domestic Violence & Incest Resource Centre	Statewide	9486 9866	Provides information in the forms of pamphlets, books, contact details for local support services.	
Centre Against Sexual Assault Victoria	Murrindindi & Mitchell Shires	5831 2343 9349 1212 1800 806 292	Counseling for women, men and children who have experienced sexual assault or abuse. You can call reverse charges or phone 1800 806 292.	☎24
Bahloo Support Group	Seymour	0407 535 036	Confidential support group for women who have been abused in any way – past or present	

More information

- Lists of service providers are available via your local library or shire office or the Yellow Pages (look under "Community" and "Organisations").
- There are also sites specifically about the challenges of early parenthood and postnatal depression. Try visiting:

www.beyondblue.org.au/postnataldepression

www.breastfeeding.asn.au (Australian Breastfeeding Association)

http://wellwomens.rwh.org.au (Well Women's site , Royal Women's Hospital)

www.wire.org.au (Women's Information and Referral Exchange)

www.rwh.org.au/bess (Breastfeeding Education and Support Service)

This Resource Guide was initially developed by Women's Health Goulburn North East as part of the Looking After Mothers Project. The Mitchell Shire Council Maternal Child Health Service has updated this edition. If your service is not listed or you notice an error please let us know by calling the Maternal and Child Health Coordinator on Tel: 5734 6200.

Please photocopy and distribute as widely as possible!

WOMEN'S HEALTH
GOULBURN NORTH EAST

MITCHELL
SHIRE COUNCIL

Resources for Mums

Support, advice, assistance in the Shires of Mitchell & Murrindindi

Looking After Mothers Project

(February 2005)

Who can help me?

Every woman can benefit from help and support. Getting help doesn't mean you're not coping; it just makes it easier to enjoy motherhood. If you do have problems, sharing can make them easier to deal with. Problems rarely go away when we ignore them.

We all have **our own** inner resources like courage, **experience**, and **knowledge** that we draw upon in troubled or difficult times. As well, there are external resources, like **friends and family**, who can also give assistance. Sometimes **professionals** can also provide a helping hand. If you need some extra assistance, you might wish to think about getting **information, advice or support** from some of the service providers listed over the page.

Social support is important! Everybody needs **friends close by**. Good places to make friends include **Neighbourhood or Community Houses, playgroups, exercise groups or walking groups**. If you're not a group person, you could ask your Maternal & Child Health Nurse to link you up with some other mums.

Sometimes it's hard to take the first step in asking for help and support. Remember that **you deserve** as much help and support as you need to **enjoy this special time.**

How to use this guide

The guide over page gives you some brief information about key local and statewide services. The areas covered by different services can vary, but as a rule:

- Most local governments provide services to people living and/or working within their boundaries
- Many services provided by Mitchell Community Health Service are also available to residents of Murrindindi Shire
- Most of the services listed here are Government funded and most are provided at little or no direct cost to the user
- Some agencies may sometimes provide an "outreach" service, in which a professional may provide their services in or close to your home or another mutually safe and comfortable place. These services are identified by the symbol 🚗
- Some agencies provide 24 hour telephone support and advice. These services are identified by the symbol ☎

Handy hints for using professional services

- Before you make contact with a professional, it might help to think about what you want to say. If you have questions to ask, you might wish to write them out in advance.
- If a professional says they have a waiting list or cannot provide you with the help you need, ask them to give you the name of someone who can. Speak up if you feel your need is urgent!
- Remember that not everybody gets along all of the time! Even if you don't feel immediately comfortable with a professional, sometimes it is worth giving it a few sessions. If you still don't feel comfortable, you might wish to try someone else.
- Everyone has the right to professional and non-judgmental care. If you are not satisfied with the service you get, you may make a complaint to the professional or to the manager of the service. If you are still not satisfied, you may take your complaint to the State Ombudsman (1800 806 314).

SERVICE	LOCATION	CONTACT	BRIEF DESCRIPTION	SPECIAL NOTES
Sources of information & referral				
Women's Information & Referral Exchange (WIRE)	Statewide phone service	1300 134 130	Has a huge database of services and professionals (both public and private). Can give you some ideas about professionals whom other women have found especially helpful. Staffed by trained female volunteers.	
Women's Health Goulburn North East	Hume region, covers Mitchell & Murrindindi Shires	5722 3009	Information and library on a wide range of women's health issues.	
Women's Health Victoria	Statewide phone service	03 9662 3742 1800 133 321	Offers a huge range of information on a wide range of women's health issues.	
Emotional support				
Social Workers Mitchell Community Health Service	Outreach based at Broadford	5784 5555	One-to-one and family counseling to assist with emotional issues, including depression and anxiety.	🚗
Counselors Goulburn Valley Family Care	Seymour, Wallan, Kilmore, Kinglake	5799 1711	One-to-one and family counseling to assist with emotional issues, including depression and anxiety.	
Family Counselor Murrindindi Shire	Outreach based at Alexandra	5772 2132	One-to-one and family counseling to assist with emotional issues, including depression and anxiety.	🚗
Goulburn Valley Area Adult Mental Health Service	Outreach based at Seymour	1300 369 005 5792 3929 5832 2111 ah	Counseling and support for women 18 yrs of age and older, or their partners who are experiencing significant emotional or mental health concerns.	🚗
Post & Ante Natal Depression Association (PANDA)	Melbourne	9428 4600	Information & support for women experiencing or concerned about antenatal or postnatal mood disorders.	
There are not many private counselors or psychiatrists in this region. You could start by asking your General Practitioner and/or calling your local hospital. You could also look up the following in the Yellow Pages: Counseling; Psychologists; Medical Practitioners.				
Practical support				
Financial counselor Mitchell Community Health Centre	Murrindindi & Mitchell Shires	5784 5555	Provides information and support for people experiencing financial difficulties, especially debt.	🚗
Post Acute Care	Murrindindi & Mitchell Shires	5793 6162	Usually arranged during a public hospital inpatient admission. Only public hospital patients are eligible. Ask your MCH nurse or hospital for further details.	
Dial a Doula (International College of Spiritual Midwifery)	Murrindindi & Mitchell Shires & Melbourne	9818 1177	Can provide physical, emotional and informational support to women and their families before, during and after childbirth. A private, fee charging provider	🚗
Carers' Respite & Information Service	Hume Region	5831 3611 5799 1711	Support service for carers of aged or disabled person. Tel: 1800 059 059 also available.	
Physical health				
Well Women's Clinic Mitchell Community Health Service	Broadford	5784 5555	Free and confidential service providing pap smears, breast self-examination instruction, pregnancy tests etc. Provided by female Registered Nurses with specialised training in family planning and sexual and reproductive health. Appointments essential.	
Well Women's Clinic Seymour Women's Health Service Seymour District Memorial Hospital	Seymour	5793 6100	Free & confidential service providing pap smears, family planning advice & information related to women's health issues. Provided by female Registered Nurses with specialised training in family planning & sexual & reproductive health. Gynaecologist available for referral.	
Physiotherapist, Dietician etc Mitchell Community Health Service	Outreach based at Broadford	5784 5555	A range of services to help your physical recovery after childbirth. Physiotherapy in Broadford only.	🚗
Murrindindi Community Health Centre	Outreach based at Eildon	5774 2404	A range of services to help your physical recovery after childbirth, including physiotherapy & dietary advice.	🚗
Home and Community Care Mitchell Community Health Service	Outreach based at Broadford	5784 5555	Funded to assist those who are frail, disabled or aged. A minimum fee of $6.50 may apply. Physiotherapist and counselor available to give advice via telephone.	🚗
Doctors and General Practitioners are listed in the Yellow Pages under "Medical Practitioners". Physiotherapists can help with back pain, pelvic floor exercises and regaining strength & fitness after pregnancy. You might also wish to think about alternative or complementary therapies such as acupuncture, massage, naturopathy, or chiropractic. For these private practitioners, look in the Yellow Pages under "Alternative Health Services".				

SERVICE	LOCATION	CONTACT	BRIEF DESCRIPTION	SPECIAL NOTES
Early parenting support				
Maternal & Child Health Service Mitchell Shire	Mitchell Shire	5734 6200	The Maternal & Child Health service is a free source of local assistance, support and advice for parents of children 0-6 years. MCH nurses are experienced in helping with breastfeeding concerns, PND and a range of child & family health issues. Call your local Shire office for details of your nearest centre.	
Maternal & Child Health Service Murrindindi Shire	Murrindindi Shire	5772 0333		
Maternal & Child Health Line (24 Hour Telephone Service)	Statewide phone service	13 22 29	24 hour support and advice line staffed by MCH nurses. Provides information about maternal health and child health and behaviour for babies to preschoolers.	☎24
Parent Line	Statewide phone service	13 22 89	Telephone support & information service about parenting babies through to teenagers.	
Kilmore and District Hospital	Kilmore	5734 2000	The hospital provides local maternity services including antenatal, labour and postnatal care. It has a 24 hour Emergency service where Registered Nurses triage patients presenting with accidents or emergencies, with GP's on call as required.	
Seymour Memorial Hospital	Seymour	5793 6100	The hospital provides a midwife-led model of maternity care, which includes antenatal, labour and postnatal care. In the Emergency area Registered Nurses triage patients presenting with accidents or emergencies & refer for appropriate care as required.	
Breastfeeding Support				
Australian Breastfeeding Association	Statewide	Melb office: 9885 0653	Central office provides a list of rostered volunteer counselors who provide telephone support from their own homes. (Have a pen & paper ready & understand that sometimes they may need to call you back). The local ABA group is in temporary recess, to resume when a new counselor completes training.	☎24
Northern Breastfeeding Centre	Lalor	9465 6786	These publicly run breastfeeding /lactation day-stay clinics provide assessment, management & support for mothers and babies who need assistance with breastfeeding issues. They are staffed by a Lactation Consultants. Suburban and rural centres generally operate only 2-3 days per week but most city centres are open Monday-Friday. If you have breastfeeding difficulties contact them early as there is often a waiting list.	
Breastfeeding Support Service	Shepparton	5831 1370		
Breastfeeding Support Centre, Mercy Hospital for Women	Melbourne	9270 2222		
Mercy Women's Clinic, Ivanhoe	Ivanhoe	1300 657 501		
Breastfeeding Assessment Service, Royal Women's Hospital	Melbourne	9347 3024		
Days stay programs and/ or residential programs for early parenting support				
Parent-Child Program Goulburn Valley Family Care	Seymour (fortnightly)	5831 1217	Day-stay program for families experiencing difficulties because of feeding, settling or behaviour problems with children 0 – 2 years. All bookings are made via the Shepparton office.	Operates in Shepparton weekly. .
Goulburn Valley Family Care	Seymour	5799 1711	Range of services to help people who need emotional support or who wish to enhance their parenting skills. Specialist children's and men's workers.	
O'Connell Family Centre	Canterbury	8416 7600	These early parenting centres are publicly run facilities providing parenting advice and support for families experiencing significant difficulties because of feeding, settling or behaviour problems. They are able to assist with mild postnatal depression. The services operate day-stay and residential programs. There is often a waiting list.	
Queen Elizabeth Centre	Noble Park	9549 2777		
Tweddle Child and Family Health Service	Footscray	9689 1577		
North Park Private Hospital	Bundoora	9467 6022	These private hospitals have residential mother-baby units providing parenting advice and support for families experiencing significant difficulties because of feeding, settling or behaviour problems. They are also able to assist with mild to moderate post-natal depression. Many also have day stay programs.	
Mitcham Private Hospital	Mitcham	9210 3222		
Masada Private Hospital	St Kilda East	9038 1300		
Mother-Baby Unit Mercy Hospital for Women	East Melbourne	9216 8465	These specialised centres provide treatment & support to women experiencing moderate-severe PND in mother-baby units. Both mothers and babies are admitted, and support is available to fathers.	
Parent-Infant Unit Albert Road Clinic (private)	Albert Park	9256 8322		
Banksia House, Austin Health	Heidelberg	9496 2199		

Appendix 13

Participants' Demographic Information

Appendix 13. PARTICIPANTS DEMOGRAPHICAL INFORMATION – 'Mum's the Word" Research Project

No	Pseudonym	Age	Marital Status	Occupation		Parity	Location of Home	Housing	Housing Changes During Study	Source of Initial Contact
				Participant	Baby's Father (Age & Occupation)	Gravida Para	-small rural township -medi rural township -rural area	1. House 2. Flat s	nil	1. advertising pamphlet 2. personal invite at antenatal clinic 3. presentation to or antenatal class
1	Xerri	27	Married	pharmacy assistant	33yr, labourer	G1 P1	Small rural township	House	nil	pamphlet
2	Angela	31	Married	administration	36yr, real estate	G1 P1	Rural	House	nil	pamphlet
3	Jess	18	Defacto	cook / kitchen hand	21yr, vineyard worker	G1 P1	Small rural township	House	Separated from partner after birth. Moved back home with parents and siblings	pamphlet
4	Sarah	23	single	mechanic	29yr, mechanic	G1 P1	Rural	Home with parents during late pregnancy & postnatally.	Moved out to flat when baby about 9 weeks.	personal invite at antenatal clinic
5	Rose	28	Married	office admin / massage therapist	31yr, armed forces	G1 P1	Small rural township	House	nil	pamphlet
6	Christie	34	Married	book keeping	35yr, accountant	G1 P1	Rural	House	nil	via antenatal education class
7	Gail	27	Married	pharmacy assistant	28yr, fitter	G1 P1	Rural	House	nil	personal invite at antenatal clinic
8	Ursula	30	Married	paramedic	30yr, TV producer	G3 P1	Rural	House	nil	via antenatal education class
9	Bernadette	30	Married	librarian	31yr, labourer / musician	G1 P1	Small rural township	House	nil	personal invite at antenatal clinic
10	Kate	27	Married	home duties	29yo, maintenance fitter	G1 P1	Rural	House	nil	via antenatal education class
11	Lee-ann	30	Defacto	sales consultant	35yr, truck driver	G2 P1	Rural	House	nil	via antenatal education class
12	Dianne	34	Married	journalism student / family business	33yr, self-employed -quarry	G2 P1	Rural	House	nil	personal invite at antenatal clinic
13	Hayley	25	Married	office admin	25yr, carpenter	G1 P1	Medium rural township	House	nil	personal invite at antenatal clinic
	Summary	(18-34) Av age =28yr	Married=10 Defacto=2 Single=1		(21-36 yrs) Averag e=30.5 yr	G1 P1 x10, 1 x misc, 2 had TOP (1 - TOPX1) (1-TOPx2)	8 live in rural areas 4 live in small rural townships, 1 lives in medium rural township	12 living in houses with partner 1 single mum returned to live with parents	11 living in house with partner, 1 returned to live with parents, 1 moved from parents to own flat with baby	Pamphlet =4 Personal invite at clinic =5 Presentation to antenatal education class = 4

Appendix 14

Participants' Birth Outcomes

Appendix 14. PARTICIPANTS and BIRTH OUTCOMES – 'Mum's the Word" Research Project

No	Pseudo -nym	EDD	Actual DOB	Gest	Elev BP	Pre-eclampsia	Ante-natal Admission	Attempted Induction	Epidural	Labour (hrs)	Childbirth				Perineum		PPH	Other	Hosp. locat. code
												Assisted Delivery			Epis or 2nd degree tear	Third degree tear			
											Normal	Vacuum	Forceps	C/S					
1	Xerri	4.3.05	12.3.05	41.+3						12		X			X				1
2	Angela	7.5.05	11.5.05	40.+4						12	X	failed			X			Synto augmen	2
3	Jess	28.5.05	24.5.05	39.+3					X	14			X theatre		X			Spinal leak Blood patch	3
4	Sarah	22.5.05	1.6.05	41.+3					X	17				X Foetal distress	N/A		600 ml	Synto augmen	2
5	Rose	2.7.05	5.7.05	40.+3	X		X	2 attempts failed		9	X				intact				1
6	Christie	5.8.05	7.8.05	40.+2	X	X	X			10.5	X					X		Synto augmen	4
7	Gail	28.7.05	28.7.05	40	X		X	Tape removed		8		X			X				1
8	Ursula	2.8.05	3.8.05	40.+1	X	X	X	Tape fell off		26		X			X		600-700 ml	Synto augmen	1
9	Bernadette	17.9.05	20.9.05	40.+3					X	24		X			X		850 ml		1
10	Kate	19.10.05	14.10.05	39.+2					X	28		X	X			X	PPH		1
11	Lee-ann	29.10.05	13.10.05	37.+5	X	X	X	3 attempts failed	X	nil				X failed induction, PE	N/A		PPH 1◦ & 2◦	Blood Transfusion Currete	1
12	Dianne	30.10.05	5.11.05	40.+5					X	21			X theatre		X	X	PPH	Vag. Packs Drain tube	3
13	Hayley	30.12.05	1.1.06	40.+2					X	43		X	X		X			Synto aug	1
	Summary				5	3	5	4	7		3	7-attempts 6-actual	4	2	8	3	6		

Appendix 15

Permissions for Images

Leanne Sheeran

From: Jennie Moloney <Jennie.Moloney@ngv.vic.gov.au>
Sent: Friday, 2 December 2011 9:37 AM
To: 'sheeran_al@aapt.net.au'
Subject: Ron Mueck images for your thesis

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Leanne

Thank you for your recent letter seeking permission to reproduce a number of images reproduced in our *Ron Mueck* catalogue in your doctoral thesis.

Whilst we can grant you permisison to scan the pages from our catalogue and use the material in your thesis, please note that the works are not in this gallery's collection and are also in copyright so should you wish to publish the material at any point in the future you would need to seek permission from the owners of the works, obtain reproduction quality images to reproduce from and obtain copyright approval from the artist to publish the images.

The Australian Copyright Act does allow for works of art in copyright to be used for personal study and research without having to obatin copyright permisison so to include the images in your thesis you will be presenting for assessment will be fine.

I trust your research is proceeding well.

Kind regards
Jennie Moloney

Jennie Moloney
Senior Publications Coordinator
National Gallery of Victoria
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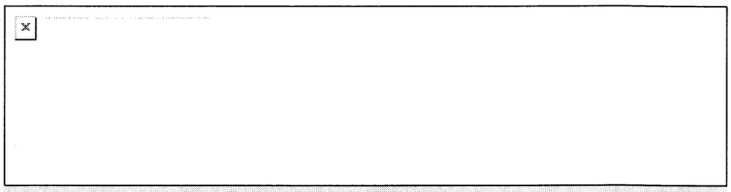
Telephone: +61 3 8620 2209
Fax:8620 2555
ngv.vic.gov.au



Leanne Sheeran

From: Marilyn Harre <marilyn.harre@demdaco.com>
Sent: Wednesday, 7 December 2011 3:47 AM
To: sheeran_al@aapt.net.au
Subject: FW: Permission to use Willow Tree images in PhD thesis

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: Red Category

From: Marilyn Harre **On Behalf Of** Willow Tree
Sent: Tuesday, December 06, 2011 10:35 AM
To: 'sheeran.al@aapt.net.au'
Subject: RE: Permission to use Willow Tree images in PhD thesis

Dear Leanne:
We very much appreciate your asking permission to use Willow Tree images in your Ph.D. dissertation, and we commend you for such an arduous course of study. You can be proud of your achievement; the health and welfare of mothers and children is a most important topic.

Normally, we have to say no to people and organizations that wish to use Willow Tree images or logo. Our licensing agreement allows only retailers to use images when they are promoting the sale of the three-dimensional sculptures as they currently exist (store fliers, advertisements, catalogs, etc.). Retailers must have a land-based store, with an account in good standing with DEMDACO. The Willow Tree trademark, logo and copyrights are the property of Susan Lordi, and products, images, and logo are protected by US and international copyright and trademark laws.

But this is a private request, so we would be most honored for you to use selected Willow Tree images in your Ph.D. dissertation. We do need to caution you not to sell or reproduce the images in any way other than your dissertation.

Thank you so much for contacting us. We wish you a very happy holiday season.
Sincerely,
Marilyn Harre
DEMDACO

From: Kevin Price **On Behalf Of** customercare
Sent: Wednesday, November 30, 2011 2:08 PM
To: Willow Tree
Subject: FW: Permission to use Willow Tree images in PhD thesis

If I can be of further assistance let me know.

Thank You,
Kevin Price
DEMDACO Customer Care
kevin.price@demdaco.com
1.888.336.3226 ext 139